Local Education Authorities' approaches to provision for children with specific speech and language difficulties in England and Wales

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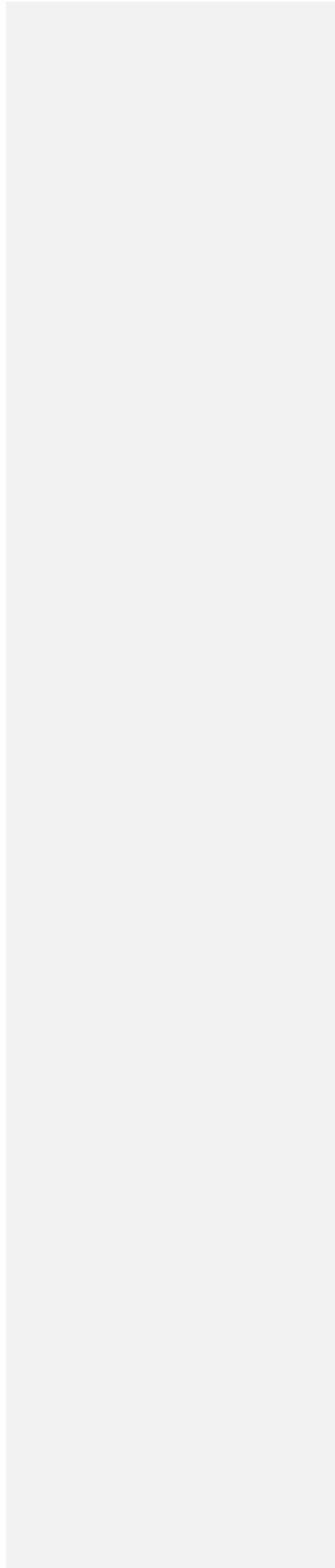
Abstract

Children with specific speech and language difficulties (SSLD) pose a challenge to the education system as a result of their language needs and associated educational and social-behavioural difficulties. Local education authorities (LEAs) in England and Wales have developed language units to meet their needs but previous research had indicated this provision was inadequate. The development of inclusion raises questions regarding this type of this provision, compared with full inclusion into mainstream schools. The present study reports on a national survey of LEAs in England and Wales (97 respondents, 49.5% response rate) and interviews with 37 LEA special educational needs managers. Provision varied by age group with designated specialist provision more prevalent at kKey Stages 1/2 (age 5 – 11 years), and relatively little at Key Stages 3/4 (11-16). LEAs' Ddecision-making regarding provision was found to be varied, influenced by the lack of common criteria, which was highlighted by the difficulties in distinguishing children with SSLD from those with autistic spectrum disorder. There were also, and difficulties translating policies into practice, including the shortage of speech and language therapists. Autistic spectrum disorders were considered to be increasing and influencing provision for children with SSLD but there was doubt that this reflected a real increase in incidence rather than different diagnostic approaches. The implications of the study are discussed with reference to inclusion.

INTRODUCTION

Children with specific speech and language difficulties (SSLD)[3] have a primary language problem. That is, the problem is not attributable to intellectual impairment, severe or profound hearing loss or lack of linguistic opportunity, (Leonard, 1997). The more common term is the research and clinical literature is specific language impairment (SLI) which is synonymous with the term specific speech and language difficulties (SSLD) often used in the UK, particularly by educationists. Prevalence studies suggest that the numbers of children concerned are substantial, about 5-7%. (Law, Boyle, Harris, Harkness, & 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, & Kaplan, 1998), poor academic attainments (Snowling, Adams, Bishop, & and Stothard, 2001) and social-emotional problems (Beitchman, Wilson, Brownlie, Inglis, & and Lancee, 1996; Fujiki, Brinton & Clarke, 2002; Lindsay & and Dockrell, 2000). Thus, while the children present with core deficits in the area of language, associated problems increase risk of academic difficulties and therefore have implications for support provided by LEAs and health trusts (Dockrell & Lindsay, 2002).

A common approach to meeting the children's educational needs has been the provision of language units within or associated with mainstream schools, with children experiencing more serious difficulties attending specialist (often residential) special schools. As early as 1987 Hutt and Donlan expressed concern that there were about half as many units for junior aged children aged 8 to 11 years at (Key Stage 2

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[3] 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.impairment

(KS2)) as opposed to infants aged 5 to 7 (KS1) (349:654 children respectively) in their sample of 108 of the 200 Units, and only 39 pupils in secondary Units. Criteria for admission, the nature and extent of integration, the use of manual signing, and staffing ratios all showed considerable variation. Furthermore, the teachers had no consistent pattern of specialised training.

Since that time, there have been major changes in the education system in England and Wales following legislation (Education Reform Act 1988; Special Educational Needs and Disability Act (SENDA), 2001); various initiatives of the Labour Government (Green Paper: Department for Education Employment (DfEE), 1997; SEN Action Plan: DfEE, 1998; Department for Education &and Skills (DfES), 2001a,: and the present Strategy for SEN: DfES, 2004); reorganisation of local educational authorities (LEAs) and the National Health Service (NHS); developments in professional and administrative practice by LEAs and health trusts; and the implications arising from legal interventions, including judicial reviews. Moreover, it has been recognised that not all children with SSLD will be found in language units or specialist provision although there has been little systematic empirical evidence to substantiate this view.

A number of factors are likely to influence the educational provision for children with SSLD. Variation in LEA practice results in different patterns of placement across a range of provision. This may be planned, or a result of inadequate identification and assessment, or a lack of appropriate facilities. Dockrell and Lindsay (1998) report that about two thirds of the children with significant degrees of language impairment, and hence high levels of need, in their study were in mainstream provision rather than special units or schools. Also, LEAs may use

provision for children with SSLD designed for a broad range of children with SEN, or those with, for example, specific literacy difficulties.

Consideration of educational provision for children with any special educational needs (SEN) must take account of the development of moves towards a more inclusive system of education embedded in legislation, the most recent of which is the SENDA (2001) supported by the government's SEN Strategy (DfES, 2004) and the enhanced involvement of parents in partnership with professionals (DfES, 2001b). Although there is general support for the principle of inclusion, there is also concern about the implementation of a policy which may lead to provision which is 'inclusive' but not meeting the children's needs (Ofsted, 2004). Recent legislation and indeed much practice has been driven by concerns for the rights of children with SEN to be included, rather than by evidence of the more effective forms of education for different children (Lindsay, 2003). There is also concern about the ability of teachers to implement effective programmes. For example, Dockrell and Lindsay (2001) found that the teachers supporting children with SSLD in mainstream schools felt unprepared, as a result of lack of training, and generally unsupported, so raising questions about the efficacy of the inclusion being experienced by the children. Botting et al (1998) report that after transfer from KS1 language units almost half the children were being educated after transfer in provision their teachers did not consider 'ideal'. This is a cause for concern for parents (Lindsay and Dockrell, 2004).

Determining educational provision for children with SSLD must address the issue of definition. This problem is not unique to SSLD but is evident in relation to provision for both children with Moderate Learning Difficulties (MLD) or social, emotional and behaviour difficulties (SEBD). Despite the heterogeneous nature of the population with language impairments (Conti- Ramsden, Crutchley &and Botting,

1997; Rapin &and Allen, 1983) there is a common set of clinical criteria used to identify the population ofthe children with SLI (see DSM IV (American Psychiatric Association, 1994) or ICD-I0 (World Health Organisation, 1992). As noted above, in the UK the term specific speech and language difficulties (SSLD) has become a synonym for SLI and is preferred by many educationists. Substantial variation in needs can occur in an educational context partly resulting from the children's associated difficulties (Botting, et al., 1998; Dockrell and Lindsay, 2000). Unlike other areas of special educational needs children In addition, children with SSLD typically have needs that require input from both health, especially speech and language therapy, and education services.narrow Substantial variation in needs can occur in an educational context partly resulting from the children's associated difficulties (Botting, et al., 1998; Dockrell and Lindsay, 2000).

The purpose of the present study was to address the current provision made by LEAs in England and Wales for children considered to have SSLD, including designated special provision in mainstream schools in the form of Units or Integrated Resources; special schools, both those specifically for children with SSLD and others, especially for children with moderate learning difficulties (MLD); and provision in individual mainstream schools without designated special provision.

In the UK LEAs are regional authorities ranging in size from small cities to large areas comprising towns and rural areas which have responsibilities for the delivery of education services. In particular, LEAs have responsibilities under the Education Act 1996 for the assessment of and making provision for children with special educational needs.

Historically provision for children with *specific* language difficulties (SLI/SSLD) has excluded children with autism. However, the prevalence of

pragmatic difficulties among this population has become more evident and the concept of autistic spectrum disorders has developed, bringing a substantially larger group of children into consideration. Advisors to the research in its inception phase indicated that LEAs were now changing the remit of specialist language provision to include children with ASD. This change in policy had also been influenced by the reportedly substantial increase in the numbers of children diagnosed with ASD (Charman and Baird, 2002). Consequently the The overlap with autistic spectrum disorder (ASD) required that the inter-relationship between these two categories and the impact on provision needed to be explored. This had become increasingly important given the apparent increase in the number of children diagnosed with ASD (Charman, 2002; Charman & Baird, 2002).To address this objective iIt was necessary to consider a) the variation in identification and assessment practices, both between and within LEAs and b) to examine overall planning and organisational processes for the determination of provision for individual children with SSLD (and ASD). For example, children may be determined to have SSLD but, in the absence of optimal provision, alternative support may be made. A systems analysis also required investigation of collaboration between health and education, and the practices of speech and language therapists (SLTs).

The present study focussed on children with SSLD in England and Wales, and this remained its primary orientation. However, as the study started there was increasing interest nationally in children with autistic spectrum disorders (ASD) and a substantial increase in research investigating the profile of needs experienced by children with pragmatic language impairment. Our initial interest in these children was methodological, namely the construction of questionnaires which focussed on children with SSLD and which were not confounded with those children with ASD.

However, this methodological issue became superseded by the question of children with ASD themselves. The national debate had been energised by claims linking a suggested increase in children with ASD to the use of MMR vaccine (Charman, 2002; Charman & Baird, 2002). This debate was often focussed on causal links and did not necessarily take the condition of ASD, its definition and diagnosis, as a key problematic issue. Consequently, we decided to add a subsidiary investigation of ASD into the study. This focused on the overlap between SSLD and ASD, both conceptually and in terms of provision, and in professionals' views of the trend in ASD. Hence this study of key professionals' opinions supplemented the major study of SSLD.

<div align="center">METHOD</div>

The study was carried out in England and Wales and built upon earlier research funded by the Department for Education and Employment, Department of Health and the Welsh Assembly, which investigated collaboration between education and health services in providing for children with speech and language needs of all types (Law et al, 2000). A survey of local education authorities (LEAs) and speech and language therapy services carried out as part of that project provided information on provision, but not on that specifically for children with SSLD (Lindsay et al, 2002).

<div align="center">Samples</div>

<div align="center">*LEAs*</div>

The three samples investigated were LEAs, speech and language therapy services, and schools. There was a 2-stage process, with national questionnaires to all LEAs and SLT services, followed by interviews with a sample of each[4]. Finally,

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[4] Copies of the questionnaire are available from the first author

interviews were held with a sample of schools which provided for children with

SSLD. The present paper reports the findings fromof LEAs.

A questionnaire was sent to all local education authorities in England and

Wales (N=196). Ninety-seven responded, a response rate of 49.5%. Forty of the LEA

respondents were selected for the second stage, comprising an interview with the LEA

representative: 16 LEAs were selected as coterminous with the health trusts, the

remaining 24 were selected at random. There were 37 completed interviews; three

respondents were unavailable. Normally the interview was conducted with the same

person who completed the questionnaire; however on five occasions this person had

left the position, or did not feel that they were the most appropriate interviewee. In

these cases another relevant senior officer was interviewed as advised by the LEA.

The respondents were predominantly education officers with responsibility for SEN,

but also included senior educational psychologists and advisory teachers.

<div align="center">Measures</div>

The questionnaire[5] was piloted on a small number of appropriate professionals

including an advisor for special educational needs, education officer for I-CAN the

voluntary body in the UK for all children with speech and language difficulties, and

an LEA education officer with responsibility for special educational needs(SEN). One

assumption was that there would be variation in conceptualisation of 'specific speech

and language difficulties', and that this would have implications for provision. This

posed a methodological problem, however, as it was necessary for the questionnaire

to have sufficient clarity regarding the target population of children to enable

successful completion while still allowing respondents the opportunity to specify the

term they used. The main issue arising from the piloting phase was the potential

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[5] Available from the first author

overlap between SSLD and autistic spectrum disorder (ASD). This was addressed by not only improving theThe following guidance for completion of the questionnaire was provided:, but also by including a question specifically addressing the issue of SSLD/ASD overlap.

"The purpose of this questionnaire is to identify provision for children with *specific speech and language difficulties* (SSLD) i.e. those with a *primary* language problem, not attributable to severe/profound hearing loss, physical disability, autistic spectrum disorder (ASD) or severe/profound learning difficulties".

The issue of ASD was addressed by questions specifically targetting the question of SSLD/ASD overlap, namely: 'Is provision for children with SSLD also used for children with ASD?' and 'How do you see the relationship between your provision for children with SSLD and those with ASD developing? 'In each case, respondents could also add comments.

The questionnaire mainly comprised forced choice questions (e.g. Yes/No) or required specific information. After the initial questions on SSLD/ASD overlap, the questionnaire comprised five sections for Pre-school; Reception and Key Stage 1 (age 5 to 7 years); Key Stage 2 (8 – 11 years); Key Stage 3/4 (11 to 16 years); and Post 16 (16 plus years). In each case respondents were asked to specify:

"What educational provision is used for children with specific speech and language difficulties (SSLD) at the pre-school stage (or alternative as relevant). Please specify separately that made by the LEA itself, alone or in partnership with others. Please record separately, below, where the LEA funds places in provision made by others."

Respondents were also invited to specify, where appropriate, the number of schools, number of child places for each provision made.

The interview schedule was semi-structured. It was, designed to produce both comparable data on the main questions key elements, but also to allow an exploration of respondents' views in detail. An initial open-ended question was followed by prompts used where the informant did not provide the required information, or follow-on questions to elicit further information. The interview explored the interviewees' opinions regarding policy, including written policy statements on children with SSLD; practice and deviations from policy; liaison with other LEAs/voluntary bodies; provision for children with ASD; the LEA's overall approach to service delivery in educational settings; policy for parental involvement specifically for SSLD; and examples of good practice (see Appendix). Interviews were conducted by phone and typically lasted about 30 minutes.

RESULTS

Educational provision

Data reported in this section regarding the provision made by the LEAs were derived from the questionnaire study (Figure 1).

Mainstream

The majority of LEAs made provision in mainstream for children with SSLD, with the highest proportions at Reception/Key Stage 1 (98%) and KS2 (99%). However, fewer than half of LEAs made provision in mainstream post-16 (46.7%).

[Figure 1 about here]

Special provision

Pre-school.

Relatively few LEAs made provision through designated nursery schools either alone (8%) or in collaboration with the voluntary sector (1%). Of these, most (4) LEAs provided one nursery, one provided two nurseries and one provided three. Generally, these nurseries had part-time places only, from 12 to 40. Units/integrated resources for children with SSLD were more common with 23% of LEAs funding these alone, and a further 10% making provision jointly funded by either social services or the voluntary/private sector.

Key Stage 1 to post-16

Fewer than 10% of respondents provided special schools designated for children with SSLD, and these commonly had one school per age group. However, most responding LEAs provided language units: 91% at reception/KS1 and 84% at KS2, although only 29% made this provision at KS3/4 and only one authority (1%) provided it for pupils post-16. The modal number of units at each stage was one with minorities of LEAs providing up to three at reception/KS1 (one: 47%, two: 22% and three: 12%) and KS2 (one: 53%, two: 16% and three: 7%). A minority of LEAs provided between 5 and 10 at these two stages (8% and 7% respectively). The most common size was 10-20 pupils. Consequently, very few children were educated in specialist language provision in any LEA

LEAs also used other special units/resources not designed specifically for children with SSLD, particularly for younger children: 22% of LEAs at reception/KS1, 21% at KS2, approximately double the percentage reporting this for KS3/4 (11%) and post-16 (9%). The mode was one per LEA but the range was substantial (up to 20 at reception/KS1 and at KS2).

Nearly two thirds of respondents reported making provision for children with SSLD in special schools for pupils with moderate leaning difficulties (MLD) for all

age groups to the end of KS4: 60% reception/KS1; 61% KS2, and 66% KS3/4; but only 27% reported using MLD schools for post-16. The mode was one MLD school (32% – 40% of LEAs between reception and KS4) but again the range was large (1-15 up to KS2). About half of LEAs also reported using other special schools (53% reception/KS1; 52% KS2; 52% KS3/4; and 34% post-16. Use of provision made by the voluntary sector or other LEAs was also reported: 40% at reception/KS1, 47% KS2, increasing substantially at KS3/4 (70%) and also common at post-16 (40% of LEAs).

<div align="center">Policy into action</div>

<div align="center">*Policies*</div>

Data from the interviews (N = 37) are presented in the following sections to provide elaboration of the rationales underlying the implementation of the LEAs' policies. A quarter of the interviewees (9) stated that they had specific documentation regarding children with SSLD: '

We have a specific policy for children with SSLD, this has recently become official at the LEA level; it's a joint document with health, outlining specific criteria and levels of support.'

However, not all could give details: 'Yes, there is a written policy, however it is rather short'. Almost half (17) reported that there was a written policy but it was included within the overall SEN policy document. A further 9 LEAs reported only a working understanding with other professionals regarding support and criteria, with two stating that they did not know if the LEA had a specific written policy for this group of children.

Two thirds (25) of respondents stated that they had a relevant development plan, most (15) stating that the plan was directly related to children with SSLD with a

further 10 stating it was part of a general SEN plan. Of those with specific plans for SSLD, eight involved either extending or identifying new provision for children with SSLD and six addressed improving collaboration with health or increasing SLT provision. The majority specified developments at secondary or nursery level: 'extend provision for SSLD at key stage 3 and 4' or 'we have a bid to ICAN for a nursery scheme'. Other issues included greater collaboration with health colleagues, particularly to integrate therapy and education at school level, and joint training of teachers and SLTs.

Although all interviewees stated their policy was for inclusion wherever possible, further probing revealed that while 26 attributed inclusion a medium/high priority, 10 gave it a low priority. The main focus of comments by the former was to argue for more mainstream services rather than special schools: 'Definitely more inclusion. We want to develop resources for schools not more special schools'. Language units/integrated resources were often seen as examples of inclusive practice: 'We use the term inclusion though the children are mainly in language units not mainstream'. This provision was part of many LEAs' development plans: 'We have an inclusion plan and this involves increasing the number of speech and language units'.

All respondents commented that their policy was of inclusion wherever possible. However, further probing revealed that while the majority (26) implied inclusion had a medium to high priority about a quarter (10) indicated relatively low priority. Examples of the former are: "Inclusion is very much the LEA's policy, main development and aims over the next few years"; "We are working towards every child choosing to attend a mainstream school"; and "LEA has a policy of inclusion to place children into mainstream if the parents are agreeable". Those attributing a lower

priority to inclusion gave a number of reasons including having special schools which they did not want to close. Some questioned the benefits of inclusion: "Inclusion is under review; we are starting to query this practice especially for Key Stage 3 and 4". Some defined inclusion more broadly: "We use the term inclusion though the children are mainly in language units, not mainstream". Others questioned the effectiveness of the education provided: "We want children to be able to access mainstream, but to ensure achievement as well".

Criteria for provision

Excluding the two interviewees who did not know whether the LEA had a written policy, the 35 remaining respondents provided a diverse picture regarding criteria for provision for children with SSLD (Table 1). Over one third (13) stated that there were no criteria at LEA level: 'Only the needs of the child and the right environment for the child are important - there are no performance criteria'. Five reported criteria based upon severity of language difficulty. Only five provided specific criteria including assessment of different aspects of language and the notion of discrepancy between language and nonverbal cognitive ability: 'The child has to be average or above i.e. only with speech and language difficulties, which means a delay in acceptance until they are sure'. These criteria could be elaborate:

> The level of need is assessed through a ranking system, the assessment of different aspects receptive, expressive, semantic and pragmatic and through to educational ability, and how they relate to peers and adults. There is a negative scoring system operating so that a low score have mainstream and support, then a statement with specific dedicated teaching hours, dedicated provision, and the highest score out of authority.

 [Table 1 here]

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Seven stated that provision was determined through the statutory assessment process: 'The entry criterion comes from the statementing process, which is in conjunction with a panel of professionals, specialist teachers, SLT and parents'. One respondent focused on the environment of the language unit rather than the ability of the child: 'A resource for work on social communication rather than focus on the medical model of language special school as criteria'.

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Practice

Two thirds of LEAs (24) stated that they had difficulties translating policy into practice. Ten interviewees referred to difficulties caused by the lack of integration across the LEA, owing to geographical variations, or communication difficulties with schools or health colleagues: 'The most difficulty is with health. The NHS (National Health Service) is bureaucratic and it is difficult to come to agreements with health regarding provision, they do not want to follow government guidelines'. Four blamed the overall lack of funding resulting in lack of provision, which could inhibit practice, but so also could the need for training and difficulties with differential assessment of

children, each mentioned by two interviewees. Shortage of SLTs and parental wishes regarding provision were each mentioned by three interviewees as affecting the translation of policy into practice.

Parental preference is always an issue, a total lack of SLT will make parents want different provision - though we're trying to develop skills in teachers, the parents will always want direct help from the therapist and may choose a school where therapists are on staff.

Just under half (16) of the interviewees liaised with other LEAs for the allocation of provision, with arrangements often described as informal, but 19 reported little or no such liaison. A number of these stated that this was because they had enough provision for SSLD in their own LEA. Fifteen liaised with voluntary bodies for the allocation of provision, especially I CAN, the charity for all children with speech and language difficulties in the UK which funds independent schools and joint provision with LEAs and Afasic, the charity which supports parents of children with speech and language difficulties.

Most (29) interviewees stated that children with SSLD had access to out-of-authority provision including ICAN or independent schools. However, some were not happy with making this provision, partly a result of their inclusion policy or cost, and were not encouraging its continuation: 'Children do go out of authority. We wouldn't restrict them from doing so if it is in their best interests, but it knocks a big dent in the SEN budget'.

Autistic Spectrum Disorders (ASD)

A smaller proportion of interviewees than respondents to the questionnaire (22% v 45%) reported joint provision was made for children with SSLD and ASD, with the majority reporting separate provision. Many (13) interviewees were unable

to provide a specific reason for their policy, whether for separate or joint provision. Where reasons were given for separate provision a quarter of interviewees (9) stated that children with SSLD and ASD had different needs and aetiologies, even if differential diagnosis was difficult: 'We try to keep them separate as they have qualitatively different needs, however they are very difficult to separate at an early age'. Reference was also made to children with ASD being better able to access a mainstream curriculum than children with SSLD. ~~This is of note given the need to distinguish 'classic' autism, where inclusion is a major challenge owing to the severity and combination of problems, from ASD which includes milder degrees of difficulties: "There is more integration for ASD than for SSLD as we would prefer them to access mainstream".~~

Most of those making joint provision argued that both ASD and SSLD were seen as part of the 'language and communication' category by the LEA: 'We have joint provision for ASD and SSLD as language and communication is part of both'. However, one interviewee noted, 'It is difficult to draw a line between ASD and SSLD, we have specialist teachers for both at our unit provision' while others noted the lack of overall provision and geographical difficulties of large counties:

[Tables 2 and 3 about here]

Most interviewees considered that numbers of children with SSLD and especially ASD were increasing (21 and 34 interviewees respectively, see Table 2). With respect to ASD, three quarters of interviewees considered that the pattern of diagnosis had changed (Table 3). In some cases they referred to earlier or better diagnosis, a result of improved practice. However, four respondents suggested, 'The increase is due to over-labelling as opposed to under-labelling which occurred in the past'. There were also six respondents who did not necessarily impute 'over'

diagnosis, but implied changes in policies and practices by professionals rather than an absolute increase in the numbers of children: 'It's not a real increase just a change in labelling'.

Service delivery

Traditionally, speech and language therapists (SLTs) treated children in clinics either in hospital or the community, requiring children to take time away from school and limiting contact between SLTs and teachers. Most interviewees expressed a preference for delivery of speech and language therapy within schools rather than clinics. Half (19) reported that children with SSLD are seen by the SLT in mainstream schools, although they varied in the degree to which they reported work in schools as part of a definite plan, or a development whose details were not clear to them, or which was inconsistent: 'It depends on the SLT'. Work in clinics was often related to limited resources or SLT preference rather than LEA policy: 'There are different health areas and where possible children are seen in schools, though due to low numbers of SLT, more are seen in clinics as it is practical'. This practice was not always welcomed: 'Children with statements are seen in clinics. There is not enough partnership within education and work with schools'. Where there was work in a variety of settings, this was typically related to the child's needs, or a decision on optimal service delivery: 'The therapists see the children in a mixture of settings based on severity of need'.

About a third of LEAs (12) employed their own SLTs while some were working towards this. Those employing or seeking to employ SLTs wished to improve service delivery, 'We have SLTs employed by the LEA working in the same office as us which leads to greater collaboration and understanding' or overcome

existing shortages: 'In areas of our LEA there is a non-existing service, we are trying to fund our own therapists'.

Parent involvement

All LEAs referred to parent partnership schemes. In addition, about half (19) had working groups involving parents in decision-making. These were considered to be positive developments. Parental involvement in policy development could also be facilitated by engagement with voluntary bodies:

> We work with AFASICAfasic. There are two parent reps who sit on a panel and we discuss issues surrounding provision. We also have a parent forum in January, which we use to present and listen to a wide range of issues: they are very much involved.

Twelve LEAs had experienced appeals to the SEN Tribunal owing to lack of speech and language therapy, pressure for children to attend special schools or out of LEA schools, and lack of school provision: '

There has been a complaint about a child who has complex needs where we were unable to produce a complete package. There were two or three schools which were good enough but there weren't enough places.'

Developing effective practice

Twenty-four interviewees reported examples of good practice in meeting the needs of children with SSLD. In addition to good provision or staff, respondents also noted examples of training, early intervention and collaboration. Training was often driven by the development of inclusion and an increase in the use of the consultation model by SLTs, where they advised on intervention and undertook direct therapy less often, if at all. Early intervention projects included "A standard fund project which identifies children in nursery schools who have SSLD then a therapist will work with

them intensively. When the child transfers into reception the therapist and LSA transfers with them" and collaboration with a voluntary body: "There is innovative pre school provision, a 6-week block input in partnership with ICAN". Examples of effective collaboration varied from LEA/Trust level to practitioners in schools:

There are 3 schools with excellent collaboration between the LEA and Health. Also there is a phonological awareness program in mainstream with teachers, assistants and SLTs working in small group work with co-ordinated teaching programs.

Interviewees also identified areas for improvement. There was a desire for more funding to meet increased demand owing to increases in numbers of children, but also because of the additional demands arising from inclusion: "We are faced with inclusion: the primary schools are stressed". Gaps in provision focussed particularly on KS3/4. Most respondents wanted to improve the relationship with health, and an increase in SLTs, especially for mainstream schools: "There are long waiting lists to see the SLTs it leaves no scope for new children". Greater integration of services was one way forward: "We would like more integration with health and the SLT professionals, and support for our teacher partnerships".

DISCUSSION

The present study indicates that the educational needs of children with SSLD are met in a number of different types of provision ranging from individual inclusion in mainstream schools to special schools. This pattern supports that previously found in a national survey of provision for children with all kinds of language needs (Lindsay et al., 2002). However, comparison with the survey by Hutt and Donlan (1987) raises questions regarding service development. One possibly positive development has been the increase in numbers of special language units/integrated

resources within mainstream schools at junior (KS2) level for children aged 8–11 years. However, the lack of such provision at the secondary stage (KS3/4) for age 11–16 years continues, and is a cause of concern to LEAs, one reason being that SLT input is aimed primarily at this provision rather than to children individually included in mainstream schools (Lindsay et al., 2002).

Variation in the nature and use of criteria also continues. Hutt and Donlan focussed on criteria for admission to language units but the present study has broadened this to include the definition of SSLD and criteria for provision. The most common response was that LEAs had no specific criteria and instead used the statutory assessment procedure. This may be characterised as a 'needs led' approach, compared with the 'diagnostic' approach favoured by SLTs (Lindsay, Dockrell, Letchford, &and Mackie, submitted). It recognises the difficulties inherent in diagnosis of many developmental psycho-educational difficulties such as SSLD (Conti-Ramsden et al., 1997) and may therefore be helpfully flexible. However, there is also the danger that it is seen as vague not strategic, leading to unacceptable variation in provision for similar children assessed in different LEAs, or even within the same LEA. The increased numbers of children with ASD have also led to a focussing of discussion on criteria regarding the appropriate provision for each, whether together or separate. Concern about the lack of appropriate training of teachers continues, supplemented now by the training needs of teaching assistants. Such training is essential if the needs of exceptional children are to be assessed and met successfully, in whatever provision.

An overriding theme to emerge from the present study is the impact of the inclusion policy. The practice of this policy in special needs education is to increase inclusion into mainstream with a reduction of numbers in special schools. However,

the place of designated special provision in mainstream schools (language units in the Hutt and Donlan study) is unclear. Are they examples of inclusion, being in mainstream, or of segregation, given the varying degrees of separation of children for periods of time? The present study has shown that while over 90% of responding LEAs reported making provision to support children with SSLD in ordinary mainstream schools, the use of units/integrated resources was also popular, especially for ages 5-11 years, and there were seen as inclusion, for example: 'We have an inclusion action plan, and this involves increasing the number of speech and language units'.

The relative lack of provision post-KS2 was a cause for concern and many LEA plans included developing designated special provision for this age group. There are very few special language schools, but almost two thirds of LEAs made use of schools for children with moderate learning difficulties, an interesting finding as the standard definition of SSLD specifies normal levels of non-verbal cognitive ability. In our separate longitudinal study we have found a substantial minority of children attending mainstream transferring to MLD provision at KS3 (Dockrell, Lindsay &and Mackie, 2004)). This suggests provision being made on the basis of a failure of that originally made and subsequent provision being expedient rather than designed to meet children's needs.

Discussion of inclusion must address not only special schools but also, given their prevalence, the specific issue of units/integrated resources traditionally provided for children with SSLD in mainstream schools. Underlying this issue is the tension between inclusion as a right compared with effective practice (Lindsay, 2003; Lindsay & Dockrell, 2002). Most LEAs wished to develop inclusion, but many had doubts about whether inclusion in mainstream was as effective as compared with specialist

language provision at meeting the needs of the children. The case for inclusion based on children's rights has often been argued as if inclusion were the only right. However, inclusion is only one of several, competing values which might be held. Mithaug (1998), writing from an American perspective, offers freedom and equality as others. Furthermore, there are different foundations for holding an inclusive view, for example the individual's capabilities, and freedom from obstacles and facility to self-determine. If children are seen as essentially equal, inclusion requires opportunities for individuals to participate in society. If, however, we consider that children have unequal abilities then inclusion requires a degree of protection of some individuals.

Overviews, reviews and meta-analyses have failed to provide clear evidence for the benefit of inclusion (Baker, Wang and Walberg, 1994; Hegarty, 1997; Sebba & Sachdev, 1997; Madden &and Slavin, 1983; Hegarty, 1997; Baker, Wang & Walberg, 1994; Tilstone, Florian & Rose, 1998). For example, the review of meta-analyses by Baker et al (1994) found a positive but small effect size, mainly with academic achievement, but this was primarily in one of the three analyses. The evidence on effectiveness is not easy to gather, as 'inclusion' is not a simple intervention, subject to experimental manipulation. Most of the evidence gathered over the years has been on children with general learning difficulties. It is necessary to examine the specific aspects of inclusion for children with SSLD. Clearly many of the LEAs in the present study considered there was a need to continue with units/integrated resources, a policy that has some support from a study by Mills, Cole, Jenkins, and Dale (1998). However, there is a lack of evidence of the differential effectiveness of provision for children with SSLD.

A careful consideration of models of SEN and provision currently in use is required. For example, children with severe and profound intellectual, sensory or physical impairment are typically identified at birth or soon afterwards and provision to meet their SEN is made at that time. Children with MLD, by contrast, are typically not identified until after school entry as a result of difficulties in responding to curriculum demands. Children with SSLD are typically identified around the age of 3-5 years with intervention provided during the pre-school period and at KS1/2. While provision to meet the SEN of the other children specified here typically continues throughout their schooling, that for children with language difficulties typically reduces after KS2, as indicated in the present research for children with SSLD and by Lindsay et al. (2002) for the full range of children with language difficulties.

A key factor for developing inclusion for children with SSLD concerns the collaboration between health and education systems. At the level of senior managers and politicians is the need to develop joint policies which facilitate the work of practitioners. Some LEAs' development plans included joint plans with health to provide more therapy for mainstream schools. Parental involvement at this level allows their voices to influence policy, but this was far from universal, either here or in an earlier study (Band et al., 2002). At the level of practitioners, speech and language therapists, teachers, and SLT or teaching assistants, there is a need for agreed understanding of practice as well as collaboration and coordination of service delivery. Several models are available but SLTs have recently been moving to an increased use of the consultation model, as identified here also (Law et al., 2002). This can be a concern to teachers and parents who see it as a reduction in skilled hands-on work with the children by SLTs (Band et al., 2002) unless the practice is agreed and the teachers and assistants are skilled in its use. In the present study some

LEAs reported teachers feeling out of their depth (see also Dockrell & Lindsay, 2001). The importance attached to training by the LEAs reflects these concerns and many of their examples of effective practice focused on the training of mainstream teachers, or models of teachers and therapists collaboratively enabling the schools to provide therapy.

Collaboration also requires common understandings and criteria for assessing and making provision for children with SSLD, but the present findings suggest variation between LEAs, compounded by different models found also from the reports of SLT managers (Lindsay et al., in preparationsubmitted). This lack of consistency was identified as a barrier to practice by interviewees. Collaboration is also important between LEAs and schools in order to develop a coherent, integrated system of provision One key issue to address this need is the provision of training, including joint training (I CAN, 2001). Another concerns funding. Inclusive education requires new partnerships and patterns of work. Designated special provision in mainstream schools can provide a more cost-effective approach by focussing expertise, which also allows training opportunities, but savings may be offset by transport costs. The use of consultation models of practice by SLTs may have cost benefits for that service, also important given the shortage of therapists, but it puts more reliance on teachers and teaching assistants, and is currently of unproven effectiveness. However, bringing SLTs into schools rather than treating children in clinics provides more opportunities for effective practice, improving mutual understanding and training.

Children with SSLD pose a particular challenge to the education system as a result of the need to address both oral language and access to the curriculum. Their difficulties often persist at least into adolescence where the latter problems predominate (Stothard, Snowling, Bishop, Chipchase &and Kaplan, 1998). In many

respects the present study suggests developments since 1987 have been limited, but LEAs now develop practice and provision firmly within a policy of inclusion. This requires careful consideration of the relative benefits of specialist designated provision in mainstream schools as well as individual inclusion of children.

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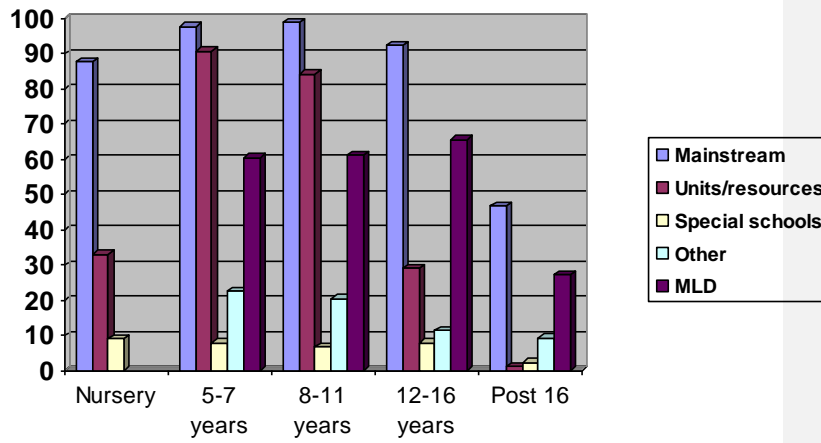Figure 1. Educational provision for children with SSLD (% LEAs)

Table 1   Criteria for placements

	LEAs
Specific criteria given	5
Severity of language difficulty	5
Statutory assessments	7
No criteria	13
Other	2
Don't know	5

N= 35

Table 2   Changes in numbers of children with SSLD and ASD

	SSLD	ASD
Increasing	21	34
Decreasing	2	0
Staying the same	5	0
Don't know	4	3
Missing	5	

N = 37

Table 3   Reasons for the increase in numbers of children with ASD

	n
Diagnosis	26
Early diagnosis	4
Over diagnosis	4
Better diagnosis	12
Overall increase in diagnosis	6
Environmental	2
Don't know	6

N = 37

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<u>Appendix</u>

1.   What is your LEA's policy for children with SSLD?

    • Do you have a written policy?

2.   What is the practice

    • Are there deviations in practice from stated policy?

3.   What liaison is there with other LEAs/voluntary bodies for provision for children with SSLD?

4.   How does your LEA make provision for children with ASD?

5.   What is the LEA's overall approach to service delivery for children with SSLD in educational settings?

6.   What is the LEA's policy for parental involvement specifically for children with SSLD?

7.   Please provide examples of any good practice you have in meeting the needs of children with SSLD.