

Date: 13 March 2002

Venue: Committee Room , National Assembly for Wales

Title: Dyfed Powys Speech and Language Therapists Response to Review of Services for Children with Special Health Needs

Special Health Needs

Description of Speech and Language Needs.

Reference: Speech and Language needs secondary to other conditions such as:

- Stammering
- Autistic Spectrum Disorders
- Hearing Impairment
- Learning Disability
- Attention Deficit Disorders
- Emotional and Behavioral Disorders
- Mental Health Problems
- Chromosomal Abnormalities
- Neurological Conditions, eg Epilepsy, Head Injury, Cerebral Palsy, Muscular Dystrophy
- Structural Abnormalities, eg Cleft Lip and Palate

It is frequently unclear in some of the above conditions to make distinctions at an early age where the boundary lies between a primary and secondary condition.

1. Early Identification – Present Position

Health Surveillance Screens

a) Health Visitor's assess children and monitor development at regular intervals in the first 3 years. Identification is based on a decision by a member of the primary care team, in collaboration with parents.

The evidence indicates that early Speech and Language problems should be a cause for concern to those involved with Child Health surveillance for the following reasons:

- The Speech and Language problem may pose problems for the individual child at the time of identification.
- The delay may indicate other co-morbid conditions, such as hearing loss, developmental and behavioral difficulties.
- Early Speech and Language problems may have implications for the later development of literacy and socialisation.

b) Additional screens are conducted by Health Visitors to identify certain groups of children. Additional training is provided to Health Visitors by Speech and Language Therapists to include:

- Screens for children at risk for early listening, skills development – Infants age 7-9 months.
- Screens for children at risk developing autistic spectrum disorders.
- Criteria for identification of children with Speech and Language problems according to developmental milestones.

c) Identification of children with Speech and Language Therapy problems by other professionals.

- Paediatricians
- Clinical psychologists/Educational psychologist
- Audiologists
- GP's

d) Baseline assessments – on school entry

- Special educational needs co-ordinator
- Class teachers

e) Multi-disciplinary/joint assessment teams:

- Special needs assessment playgroup
- Children's centre
- Paediatric feeding teams (feeding/eating disorders in children)
- Pre-term baby clinic
- Child and adolescent team

f) Assessment by Specialist Teams at regional centres:

- Cleft lip/palate centres
- Communication aids centres

g) Audiological Screening Assessment:

- Health Visitors
- School Nurses
- Audiologists
- Community Paediatrician
- GP's

What needs to be done for equality of access:

- Sufficient numbers of Health Visitors, School Nurses, Community Paediatricians, Psychologists, Child Psychiatrists and Audiologist's to provide screening and identification.
- Sufficient Speech and Language Therapy provision to assist children whose Speech and Language Therapy needs are greater than their peers.
- Regular training of primary health care professionals, teachers, speech and language therapists to ensure appropriate referrals are based on specific criteria. This component of Speech and Language Therapists work needs to be recognised as a significant part of any post when estimating the staffing ratio to service demands.

Provision of raising parenting awareness programmes to enable parental judgment to become a sensitive focus in supporting the identification process. This is likely to be population specific.

Increase the numbers of experienced Speech and Language Therapists to act as "gate keepers" on initial assessment to reduce the numbers of inappropriate, or untimely referrals. In many cases less experienced Therapists provide the initial assessment.

A substantial training commitment, of both basic training and in-service levels to primary and secondary care professionals to be made aware of the factors that help predict and mitigate against persistent problems in order to identify children whose difficulties are least likely to resolve without intervention. Speech and Language Therapists would be most likely to provide this training. This would need to be recognised by health commissions, as there is currently little explicit recognition of the need for this type of support to professionals from Speech and Language Therapists.

Active involvement by Health Visitors and other child care professionals to be involved in parent child interaction programmes supporting families with need. It would be appropriate to explore the possibility of measuring the remit of small groups to include Speech and Language work in the early years.

Prevalence rates need to be established in different populations using an agreed definition of case status.

It is important to establish the levels of need across social classes and in bilingual and diverse ethnic populations.

There needs to be a collection of national figures with a view to developing a consensus of which children need to be treated.

Children excluded from primary care:

Family support workers system to be developed to link in with health and education/social services agencies to ensure services are provided. "One Stop Shop" – a location in each Local Health Board areas which all agencies utilize and provide advice/information to parents/carers, and are able to easily liaise with professionals to alert this group.

2. Provision of information to Parents/Guardians:

a) "Breaking the news" – Model: follow up by Speech and Language Therapist to families of children with disabilities related to Speech and Language.

b) Child Development Team:

- As above "One Stop Shop" provides central information office protocols developed across agencies as to roles and responsibilities of the provision of information to families/other professionals.
- Information available at Children's Centre.
- Key worker may be appointed to family to provide information.
- Information available from National Charities/National Local Support Networkers.
- Speech and Language Therapy locally produced departmental leaflets.

c) Personal child health records.

- Joint agency production of leaflets.

3. Co-ordination of Care

a) **Children's Centre**

Co-ordination of action plan for co-ordination of care led mostly by health professionals. LEA/Social Services very rarely present.

b) **Statements of Special Educational Needs**

Needs and provision of service are identified by Speech and Language Therapists with regard to above. Needs are identified, but rarely is the Speech and Language Therapist part of the statementing panel to

represent the views of the family and present the central needs of the child.

- c) Annual review of SEN is co-ordinated by LEA Services. This generally results in lack of Speech and Language Therapy being identified with neither of the services having a suitable answer for the family/ and educators.
- d) There is willingness for Speech and Language Therapists to collaborate with agencies, but limitations upon their time. Quality is recognised, but quantity is considered inadequate by the body of Speech and Language Therapists.
- e) In some areas strategic planning is discussed with LEA's, but generally it is as a result of crisis, due to increasing levels of complaints.
- f) The co-ordination of care within child development teams is generally well planned. The over riding feature continues to be inadequate levels of support due to staff shortages and limited time to liaise with other professionals.

The willingness and co-operation to conduct a team approach is always recognised.

4. Availability of Care and Treatment

- The NHS is unable to provide the level of care/treatment as required by children with Speech and Language problems, due to insufficient numbers of Speech and Language Therapists available to provide a service.
- Offering limited amounts of Speech and Language Therapy is not a tenable solution to the problems.
- A constraint is imposed on Speech and Language Therapists by "packages of care" model of service delivery due to attempts to provide equity of service.
- Parents/Teachers, Teaching Assistants and Speech and Language Therapists approach needs of children from different levels of priorities. Often there are different perceptions of aims and priorities of intervention.
- Prioritization is a key feature of both health and SEN Service Provision, but not of mainstream provision.
- Where prioritization system co-exist, they do not necessarily concur which is likely to lead to a confused message conveyed to parents.
- The number of children referred with multiple disabilities is on the increase, including feeding difficulties. This is due to increased survival rates of children born prematurely. Speech and Language Therapists require to undertake post graduate training often at considerable distance away from the workplace.

Intervention

Location for long term effects:

- In hospital – face to face contact may be brief – time spent in counseling and preparing parents.
- At home – intervention programmes managed by parents and/or support workers.
- In playgroups (special needs or pre-school playgroups).
- In clinic – often this is an unsuitable environment due to lack of child friendly locations.
- In school – training of staff/counseling of parents/direct/indirect therapy in school.
- Recognised programmes are developed:
 - with parents
 - with education staff
- SureStart Funding has enabled certain areas to receive additional services.

What Needs to be Done

- Re-organisation of Speech and Language Therapy services is required by a system of pooling and jointly managing funds of the agencies to provide children with an inclusive education within a flexible framework.
- Increase the number of training places at undergraduate/postgraduate for an increased workforce
- Development of Speech and Language Therapy Assistants posts with a national qualification.
- Provide the financial resources to increase 2 tiers of Speech and Language Therapy Assistants – specialist grade/basic grade.
- Develop national standards for terms of employment for Speech and Language Therapy assistants to work across different agencies involved in provision of care to children with Speech and Language problems.
- Provision of sufficient personnel to provide the intervention at the appropriate level and with the appropriate frequency according to need.
- Training commitment of all parties across all agencies to be skilled and updated in working with different client groups.
- Opportunities for time for Speech and Language Therapists to research appropriate intervention strategies according to different client groups.
- Recognition that additional staffing is required to enable research to be undertaken.
- Roll out Sure Start Funding to all areas to enable early intervention to be available as a matter of course.

Shortfalls

- Lack of direct Speech and Language Therapy within school system.
- Lack of liaison time with other professionals/parents.
- Children with statements of SEN require input whilst those on lower levels of Code of Practice receive an unequal level of contact. Whereas of the lower level Code of Practice children who are

not stated may require a higher level of intervention.

- Insufficient Speech and Language Therapy specialist services within Wales to meet the needs of a variety of groups.
- Learning Support Assistants within schools assigned to children with SEN, receive on site training, rather than more formal training.

5. Support for Families/Carers

- Parents "main" concern upon "breaking the news" or recognition of a long term Speech and Language problem, is the lack of personnel available to spend time discussing possible outcomes with regard to health, social inclusion and education.
- Parents do not have easy access to respite care facilities.
- Parents require respite care/sitting service in order to spend time with members of the family/and provide more quality time with their other children.

What is Needed

- Development of family support worker as key workers to individual families.
- Development of services for:
 - Respite care
 - Sitting service
 - Counseling services for siblings
 - Holiday groups
- The above is patchy in its provision and unreliable in its frequency and availability.
- The network of family support centres needs to be extended to different environments.

6. Equipment and Other Social Service Needs

- There is no national strategy in Wales to enable funding streams to be identified and managed for children who need communication aids.
- Communication aids are vital for all aspects of a child's development and need to be readily available once appropriate devices are identified.
- The process of acquiring an aid for children is protracted and is hindered by "who shall pay".

What Needs to be Done

- National Policy with agreed funding streams.
- Protocols developed for acquiring suitable equipment.
- Significant funding to purchase aids on a year on year basis.
- Decisions made on "Who pays for what".

- Communication aids should be available on an evolving needs basis as soon as is practicably possible.
- Availability of Speech and Language Therapists to develop expertise in advising the suitability of equipment.
- Discussions with manufacturers and distributors of communication aids on an initial loans service, for best fit.
- Health/education/social services all have a responsibility to ensure children have ease of access and promptness in provision.

7. Children with Special Educational Needs

Arrangements need to be agreed between health and education agencies regarding provision of SLI:

- Adequate funding to children with SEN.
- Strategic planning of service delivery.
- Development of roles and responsibilities within schools, ie Teachers/Speech and Language Therapists.
- Additional posts to be created/provided at different levels in the school service (teaching levels).
- Agreed prioritization of levels and type of service to children with SEN (health/education).
- Speech and Language Therapists to have dedicated time to provide an adequate service within a school based service.
- Caseload levels need to be identified and then maintained.
- Commitment of joint training initiatives – health/education personnel, to enable true collaboration.

8. Good Practice

- Based on evidence based practice/clinical effectiveness.
- Joint research projects for effectiveness of intervention/collaboration.
- Development of joint assessments.
- Development of joint outcomes/measures.
- Regional/local network systems.

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