

Research Report

Meeting the needs of children and young people with speech, language and communication difficulties

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Abstract

Background: The UK government set up a review of provision for children and young people with the full range of speech, language and communication needs led by a Member of Parliament, John Bercow. A research study was commissioned to provide empirical evidence to inform the Bercow Review.

Aims: To examine the efficiency and effectiveness of different arrangements for organizing and providing services for children and young people with needs associated with primary speech, language and communication difficulties.

Methods & Procedures: Six Local Authorities in England and associated Primary Care Trusts were selected to represent a range of locations reflecting geographic spread, urban/rural and prevalence of children with speech, language and communication difficulties. In each case study, interviews were held with the senior Local Authority manager for special educational needs and a Primary Care Trust senior manager for speech and language therapy. A further 23 head teachers or heads of specialist provision for speech, language and communication difficulties were also interviewed and policy documents were examined.

Outcomes & Results: A thematic analysis of the interviews produced four main themes: identification of children and young people with speech, language and communication difficulties; meeting their needs; monitoring and evaluation; and research and evaluation. There were important differences between Local Authorities and Primary Care Trusts in the collection, analysis and use of data, in particular. There were also differences between Local Authority/Primary Care Trust pairs, especially in the degree to which they collaborated in developing policy and implementing practice.

Conclusions & Implications: This study has demonstrated a lack of consistency across Local Authorities and Primary Care Trusts. Optimizing provision to meet the needs of children and young people with speech, language and communication difficulties will require concerted action, with leadership from central government. The study was used by the Bercow Review whose recommendations have been addressed by central government and a funded action plan has been implemented as a result.

Keywords: specific language impairment (SLI), speech and language therapists, education, speech, language and communication needs, Bercow Review.

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What this paper adds

This paper provides an example of the development of evidence-based practice. The UK government has shown a commitment to develop both health and education services informed by research evidence. Addressing the needs of children and young people with speech, language and communication difficulties requires input from both Local Authorities and Primary Care Trusts and, furthermore, optimal efficiency and effectiveness requires collaboration between each Local Authority and its partner Primary Care Trust(s). This paper provides evidence for the lack of effective and efficient systems within a sample of six case studies. The need for effective collaboration between Local Authorities and Primary Care Trusts has been recognized, but the evidence from this study is that it is far from universal. At the level of policy and practice there is an unhelpful lack of collaborative planning and implementation. The research has already had an important impact as the primary source of evidence for a government review which has led to specific, funded action, including further research.

Introduction

There is an imperative espoused by governments in the UK and USA, for example, to develop evidence-based policy and practice. This paper considers the extent to which these strategic moves support the development of effective practice for children with speech, language and communication difficulties.

Children with speech, language and communication needs (SLCN) pose major challenges for the education system (Bercow 2008). The children's SLCN are argued to arise from three different causes. There are children with *primary* speech, language and communication difficulties (SLCD), the focus of this paper, where language difficulties occur in the absence of any identified neurodevelopmental or social cause. The second subgroup comprises children with cognitive, sensory or physical impairment as their primary area of difficulty but whose SLCN are secondary to their other impairment. Finally, there is a subgroup of children whose SLCN are associated with limited experiences, typically associated with socio-economic disadvantage (Hart and Risley 1995, Locke *et al.* 2002, Snow *et al.* 1998).

This tripartite distinction raises a number of complications. First, there is a high degree of comorbidity and overlapping of groups. Related to this, there is continuing debate about the specificity of diagnosis of primary language disorders, both the nature of subgroups within the category and also overlap with autistic spectrum disorder (Bishop *et al.* 2008, Lindsay *et al.* 2005b). Second, there are variations in terminology used for children with primary language difficulties. For example, a national study in England and Wales revealed that speech and language therapy services used both specific language impairment (SLI) and specific speech and language difficulties (SSLD) and other terms (Dockrell *et al.* 2006). Also, the category system required by the Department for Children, Schools and Families (DCSF) for the School Census specifies two subgroups

within a superordinate category of communication and interaction needs, namely speech, language and communication needs and autistic spectrum disorder. To avoid confusion, in this paper we use the term speech, language and communication difficulties (SLCD) to refer to those with primary language difficulties.

Third, it is not clear to what extent the problems manifested by these groups of children require different or similar interventions. Diagnostic categories, in this context, speak neither to the child's level of need nor to the efficacy of interventions.

Against this backdrop there is a need for caution when discussing prevalence statistics. Nevertheless, the proportion of children with language difficulties is clearly substantial, depending on the level of severity specified. As many as half of children entering schools in some areas of high socio-economic disadvantage have speech and/or language difficulties (Locke *et al.* 2002). About 7% of children entering school have significant primary difficulties with speech and language (Tomblin *et al.* 1997), approximately 40 000 children starting school in 2007 in England. These two populations are not identical. The former are characterized more by language delay and lack of appropriate models and experience while the latter are more likely to have developmental difficulties that may be exacerbated by social factors. Approximately 1% of 5-year-olds or more than 5500 children going into school in 2007 in England had the most severe and complex speech, language and communication needs (Bercow 2008). These children often need to use alternative and augmentative means of communication and are likely to have a long-term need for specialist help, in school and beyond.

Identification of SLCD varies by child's age. In the early years parents (Lindsay and Dockrell 2004) and the health system (Law *et al.* 1998) are key, together with professionals in early years settings. At this time, concern about oral communication is paramount. After

school entry identification of SLCD is increasingly influenced by associated literacy and social/behavioural difficulties rather than oral language, with the Early Years Foundation Stage Profile¹ and any school-based identification system contributing to the process (Lindsay and Lewis 2003). Progress through the key stages of education brings increasing language demands from the curriculum and there are associations between children and young people's SLCD and their progress in literacy, academic subjects and in their behavioural, emotional and social development (Catts *et al.* 2002, Dockrell *et al.* 2007, Joffe 2006, Lindsay *et al.* 2007, Stothard *et al.* 1998).

Identification of SLCD, therefore, is dynamic. It is a function of external demands, especially those presented by the educational system. Consequently, a simple diagnostic model of early identification is not possible as there is not a single condition to identify (compare, for example, Down's syndrome or profound hearing impairment) and, furthermore, the manifestations of SLCD vary over time (Lindsay *et al.* 2008).

As a consequence, developing services to meet SLCD is complex (Law *et al.* 2000, 2001, Lindsay *et al.* 2002). These studies identified a high level of variation in provision with specialist educational provision focused on children up to the end of Key Stage 2 (11 years) and a lack of such provision subsequently, together with substantial variation between Local Authorities (LAs) and Primary Care Trusts (PCTs) (Dockrell *et al.* 2006, Lindsay *et al.* 2005a). Service delivery also varied, for example in the use of clinics or consultative models of speech and language therapist (SLT) involvement with schools and early years provision (Law *et al.* 2002) and the role played by parents and managers in developing services (Band *et al.* 2002, Radford *et al.* 2003). Within education, service delivery is universal whereas speech and language therapy is a specialist resource delivered to a minority of children. However, this dichotomy is not unproblematic. For example, universal access and availability does not necessarily lead to universal take-up unless the provision is mandatory or rigorously promoted and monitored.

The variation in service provision also raises the issue of effectiveness. Research into the efficacy of interventions with young children with SLCD can be characterized by clinical interventions focusing on specific developmental difficulties such as stuttering or dyspraxia and more general educational interventions that aim to improve the development of various oral language skills including vocabulary, grammar and narrative. The locations may differ with the former typically taking place in clinical settings and the latter in educational provision (Herder *et al.* 2006, Law *et al.* 2003, Morgan and Vogel 2007). This evidence largely

concerns short term follow up whereas a number of more generic early years interventions have been evaluated over longer periods.²

The cost-effectiveness of early intervention programmes is well established but relatively few studies have addressed primary language difficulties and those that have done so have tended to focus on clinical interventions (Barnett *et al.* 1988, Eiserman *et al.* 1990). There have, however, been recent studies of the ICAN Early Years Centres (Law *et al.* 2005) and an early intervention programme in Scotland (Boyle *et al.* 2007).

The policy context for SLCN in the broad sense has recently changed. The importance of this group and evidence of unmet needs and lack of coordination between education and health services have been identified and the Royal College of Speech and Language Therapists (RCSLTs) in the UK have produced a policy document for action (Gascoigne 2006). Recent commissioning guidance has stressed the importance of joint working (Department of Health (DoH) and Department for Education and Skills (DfES) 2006) and engagement with the local community, especially parents (DoH 2007). The Children's Plan has provided an additional impetus.³ The approach in Scotland differs as there is no commissioning procedure as such but authorities are expected to collaborate under the Getting it Right for Every Child Legislation (Scottish Executive 2001, 2006).

Within England the political profile of SLCN was boosted when the Secretaries of State for Children, Schools and Families and for Health invited John Bercow MP—now Speaker of the House of Commons—to review services for children with SLCN (Bercow 2008). The present paper reports on a study commissioned to provide evidence to inform the review (Lindsay *et al.* 2008). The study also offered an opportunity to revisit the findings of the research by Law *et al.* (2000) to explore the extent to which limitations in policy and practice identified by that study had been addressed. This paper addresses the following research question: Is there evidence on which to base recommendations to improve the effective and efficient use of resources in services for children and young people with speech, language and communication difficulties (SLCD)?

Specific objectives were set for the study, first to assess the efficiency and effectiveness of the different arrangements for organizing and providing services in selected areas. The second objective was to determine the resources deployed across different services in these areas: phases (early years; primary, secondary, post-16); universal, targeted and specialist services; and preventative and remedial services. The third objective was to consider whether in these areas the deployment

of resources was achieving the outputs and outcomes expected effectively and efficiently.

Methods

The main design comprised six case studies; additional information was also gathered from analysis of national statistics published by the Department for Children, Schools and Families (DCSF).

Sample

Six LAs and associated PCTs were selected to represent a range of locations reflecting geographic spread, urban/rural, and DCSF data recorded in the 2008 DCSF First Release statistics (DCFS 2006) on the percentage of pupils with SLCN in primary schools (those at School Action Plus where the school draws upon the support of outside professionals such as an SLT for support and those with a statement of special educational needs). This method ensured variation on several dimensions, allowing examination of policy and practice across a range of settings. This variation was important as the study was not seeking to identify 'good practice' but, rather, the *range* of practice that exists. The sample comprised the following six case study LAs and associated PCTs:

- CS1: Inner London borough.
- CS2: Small shire county.
- CS3: Large shire county.
- CS4: Large city.
- CS5: Large city.
- CS6: Small unitary authority.

In five cases the LA and PCT were co-terminous; in the sixth case, one PCT was selected from among those covering parts of the LA.

Within each case study a range of educational provision for pupils with SLCD was identified by the senior SEN manager, taking into account age (nursery to secondary) and type of provision (mainstream, mainstream with designated integrated specialist provision for pupils with SLCD, and special schools for SLCD). This varied between LAs but, in total, visits were made to six primary and three secondary schools with specialist language resources; four preschool, two primary and two secondary mainstream schools; and five special schools.

Within each of the case studies a sample of professionals was interviewed: the LA's senior SEN manager and a senior manager in the PCT were interviewed in all case studies ($n = 12$); and the head teacher or head of integrated resource in each educational provision visited ($n = 23$). The head of the speech and language therapy service was always present in PCT interviews, either alone or with a manager to whom they reported. In schools, the

appropriate head teacher or head of the specialist language integrated resource was interviewed, and in some cases invited the SLT or the school's Special Educational Needs Coordinator (SENCo) to be present. The selection of the educational provision in each LA was determined by the LA's SEN manager. Where possible this included pre-school, primary and secondary provision and both segregated and integrated provision if it existed within the LA. The stated aim for identification of the specialist provision was to select that designed for pupils with *primary* speech, language and communication difficulties.

Procedure

Interviews were held between March and May 2008 with the LAs' and Trusts' managers and with the head teachers and heads of integrated resources, using a standard semi-structured interview schedule appropriate to each professional and setting (see Appendix A for an example). The majority of interviewees agreed to their interview being recorded to provide a back up to the field notes taken contemporaneously. At the end of the interviews ten of the twelve interviewees completed the Index of Collaboration (Law *et al.* 2000) comprising ten questions in four domains: joint strategic planning between speech and language therapy and education, and inclusion; service development at practitioner level; operational issues; and continuing professional development (see Appendix B). The other two interviewees took the Index away but did not return their completed copy.

A thematic analysis was carried out of all the interviews. Four headline themes were identified by two of the team (G. L., M. D.). These were then confirmed by the whole research team.

Results

The findings from the study will be presented thematically, exploring whether there is a sound evidence base on which to develop policy and then to consider the more specific issue of cost-effectiveness which is examined in more detail in Lindsay *et al.* (2008). In addressing the first issue an important question concerns both the presence and consistency of an evidence base and of the means to produce this across the six case studies. The evidence will be considered relative to the four identified themes, representing key areas of policy and practice.

Identification of children and young people with SLCD

The six case studies revealed substantial variation in practice with regard to identification processes. This reflected two main factors: lack of clinical agreement

about conditions and variable interpretations of the category systems used by schools for the School Census. With respect to the first issue, there was variation between and within SLT and education services exemplified by this comment from a teacher in a school with a specialist resource:

We don't have a written policy with guidelines and definitions of SLCD. It depends on the SLT and SENCO (Special Educational Needs Coordinator). (CS1 Teacher)

Interviewees highlighted the complexity including co-morbidity and lack of both professionally and administratively agreed definitions. These render consistency of practice problematic as this SEN manager articulated:

There are several different ways of using SLCD. Some use it as a term for general language and literacy difficulties, and this group would have some language and communication difficulties. Others see it as a developmental language problem, and it would include all aspects of language development. Some would include the autistic group. There are some that have language difficulties that can be catered for in primary, but in the socially and linguistically complex environment of a secondary school can't cope and show behaviour problems. These are categorized as EBD rather than SLCD. (CS2-SEN Manager)

In this study the relationship between SLCD and ASD (autistic spectrum disorder) presented particular challenges: some LAs classified these two separately but there was also evidence of conflation of the two categories. In CS5 the head of the secondary resource noted a change in its intake:

The last SLCD pupil with just SLCD left three years ago and now all are ASD. I'm not clear why this has happened.

LAs had developed different approaches to address the challenge of achieving consistency. Guidance booklets had been developed in some LAs, but adherence to the national descriptions for the DCSF School Census was varied, as were the number and nature of descriptors. Furthermore, there was variation in views on the use (and usefulness) of a diagnostic compared with a needs-related approach. The head of a secondary resource in CS3 noted that they used formal criteria and the head of CS3's special school referred to a formal diagnosis of either ASD or specific language disorder whereas the CS4 SLT manager, for example, noted that, 'there is an open referral to the service and no hard criteria laid down'.

In summary, there was substantial variation within these six case studies with respect to criteria and definitions: their nature, the process whereby decisions

are made and the approach to dealing with co-morbidity. Furthermore, some SEN managers also expressed concern about the reliability of schools' classifications because of the shortage of SLTs and the need to provide appropriate evidence to secure banded funding specified for different types of special need. In such circumstances, schools were thought to be classifying children not with respect to language difficulties, for which they needed access to an SLT, but in terms of general learning difficulties as they could more easily access appropriate assessment information to support their case for additional support.

Meeting needs

All the LAs had a general policy of increasing inclusive education and this applied to children and young people with SLCD. Of our six case studies, only one had a special school specifically for SLCD; three had SLCD provision in some of their special schools and two had no pupils with SLCD as their primary need in special schools. For example, one SEN Manager (CS4) commented that 'we are committed to providing as much integration as possible'. Policy documents stressed the children's right to inclusion. However, LAs recognized the challenge such a policy presented and often used aspirational rather than definitive statements. Concerns were also expressed about the difficulties faced by LAs in trying to develop greater inclusive practice:

I sit in meetings with head teachers saying this child shouldn't be in our school. I think that is 1990s. I don't expect it in 2008. If we are honest, a lot of our staff still believe that these children shouldn't be in universal services, they should be in special provision. (CS5 SEN Manager)

LAs also had different models of inclusion characterized by different patterns of provision. For example, whereas CS2 was moving towards supporting all children with SEN in mainstream schools and was developing its systems for funding allocation accordingly, CS4 had closed ten special schools but opened six special inclusive learning centres and CS5 continued to have high levels of specialist provision. There was also variation specifically with respect to SLCD; CS6, for example, had two special schools, one primary and one secondary, for pupils with severe and complex needs; it also had 27 pupils placed out of authority but had no pupils with SLCD in either of these special schools or in out-of-authority placements. There was similarity with the use of specialist integrated resource provision for pupils with SLCD, but LAs varied with respect to how this provided for pupils with SLCD or ASD. Provision is not only an issue of location (e.g. special versus

Table 1. Scores on the Index of Collaboration between the SEN and SLT manager in each case study

	SEN manager	SLT manager
CS1	10 ^a	10 ^s
CS2	5	2
CS3	9	– ^b
CS4	8	8.5
CS5	8	4
CS6	6	– ^b

Notes: Maximum score = 10.

^aCompleted jointly as the SLT service is integrated across health and education.

^bForm not returned.

mainstream) but also of professional practice and here too LAs and PCTs varied. Furthermore, there was an interaction between the two as different professional practices may be supported or limited by the opportunities offered by different types of provision and both may also be affected by geography, especially distance between settings.

A major factor in effective service delivery for children with SLCD is the collaboration between the LA and its partner PCT(s), in particular the SLT service. Substantial variation was found among the six case studies exemplified by the scores for the SEN and SLT manager on the Index of Collaboration (table 1). The highest level (a maximum of 10 for both respondents) was found in CS1, where the most radical approach to joint working between the SLT and LA had been developed: an integrated SLT service had been working across both health and education since 2005, with the LA's SEN manager and the head of the SLT service working together on policy development. The SLT service had also expanded considerably, from 20 posts (2005) to over twice as many in 2008. Schools were increasingly choosing to purchase more SLT time, indicating the value attributed to the service.

Compare this with CS2 with the lowest index of collaboration scores (SEN Manager = 5, SLT Manager = 2). The SLT service was small and there were also serious SLT recruitment problems. Furthermore, the service was mainly clinic based, avoiding time spent by SLTs on travel but limiting school level collaboration. CS4 had a number of operational collaborative practices but these were less well developed at policy development level. The SLT manager commented that an LA decision fundamentally to change the specialist support teacher service was made without consultation with the SLT service. As the SLT manager for CS3 did not complete the Index of Collaboration, evidence here is available for the LA only, but the SEN manager gave a very positive view, indicating a history of cooperation:

Traditionally there have been excellent working relationships between services because of long-term

joint working and commissioning. Collaboration between health and education is strong at all levels. (CS3 SEN Manager)

In summary, there was substantial variation between the case studies with respect to service delivery and the level of collaborative working, at policy and practice levels. One LA/PCT pair had developed a high level of collaboration and the success of this initiative was apparent from the schools' willingness to purchase more SLT time. Elsewhere, however, collaboration was less developed and in some cases limited. The main area where there was evidence of collaboration was the early years phase: the challenge for these LAs and PCTs was to develop this into the primary and, in particular the secondary phase of education.

Monitoring and evaluation

LAs have become increasingly 'data rich' over recent years. National databases of pupils and their achievements, behaviour (attendance, exclusions) and categories of SEN provide LAs with the opportunity to examine their own data and make comparisons with data from other LAs and nationally. These data, for example, indicate the range of pupils in each LA identified in 2005 as having SLCD,⁴ about 11% of those with SEN at School Action Plus or with a statement of special educational needs. Hence, the DCSF now collect detailed attainment data on all pupils in LAs, a process which has the potential to contribute to detailed monitoring systems. These data are based on the national systems of assessment: National Curriculum tests at the end of Key Stages 1–3 and GCSE and equivalent examinations at the end of Key Stage 4, at 16 years.

Data from the six case study LAs are presented as examples of national pupil attainment data for pupils identified as having SLCD, together with national statistics (England) for comparison, at Key Stage 2 (table 2) and Key Stage 4 (table 3). At Key Stage 2 nationally, 25% of pupils with SLCD obtained the 'expected' level 4 in Key Stage 2 English, 29% maths and 45% science compared with the percentages for all pupils of 79%, 76% and 87%, respectively (table 2). There was substantial variability between the LAs for SLCD (range zero to 47% for English); the range for the case study authorities was 17–38%.

A similar, indeed more concerning picture, was evident at Key Stage 4 (table 3) with only 15% of pupils with SLCD gaining five or more passes at GCSE level 2 (i.e. Grades A*–C) compared with the national 57% for all pupils; and only 6% of pupils with SLCD nationally achieving five or more level 2 GCSE passes including English and Maths, compared with 44%

Table 2. National Curriculum Levels (2006) for pupils with recorded SLCD in the case study authorities at Key Stage 2

Local Authority	English		Mathematics		Science	
	Eligible pupils	Level 4+ (%)	Eligible pupils	Level 4+ (%)	Eligible pupils	Level 4+ (%)
CS1	220	21	220	26	220	42
CS2	35	21	35	21	35	39
CS3	80	38	80	46	80	52
CS4	80	17	80	22	80	33
CS5	20	38	20	29	20	57
CS6	–	–	–	–	10	–
England: SLCD	5440	25	5450	29	5460	45
England: all pupils		79		76		87

Note: No data are provided by the DCSF where there is a cohort denominator of fewer than eleven pupils or fewer than six pupils in a percentage numerator.

nationally—the numbers in the case study LAs were too low for analysis and are not reported by the DCSF. Substantial variation was also evident: nationally, 64% of pupils with SLCD obtained level 1 (Grades D–G) passes including English and Maths, range zero to 100%. There were also large variations in reported numbers of children with SLCD, with LAs with similar demographics reporting substantial differences in numbers of children with SLCD.

These data derive from a national data set that allows comparisons between LAs and they are important but rather gross measures for pupils with SLCD. Consequently, there is a need to supplement these with more detailed data. Individual assessments by SLTs, educational psychologists and others may provide more finely grained and broader profiles including language and socio-emotional development as well as academic attainment. However, in order to monitor the effectiveness of the system as a whole all relevant data must be collected and analysed at LA/PCT level, not just in terms of each child's individual progress.

There was evidence of LAs utilizing the resource comprising the national assessments to assist the monitoring of their systems, but at best this was limited. The LA SEN managers knew of the data available but typically this was reported to be the responsibility of a different department. One LA manager began by stating 'I confess we are not good at monitoring' (CS3 SEN Manager). A visit to the LA's statistics section, a few minutes away, revealed that huge amounts of data were collected but analysis depended upon the receipt of specific requests and these were not forthcoming. Data were available but systems had not generally been developed to undertake appropriate interrogations. Several of our questions were met with the response 'it would be possible to get that', the point being made that such a request had not been made before. In CS4 the SEN manager commented about monitoring, 'it is currently being worked on. We need to be more robust in monitoring'.

An indication of what is possible was revealed in CS6 where a 2007 briefing paper reported the results of detailed analyses of data on pupils with SEN. For example, data in terms of national curriculum targets indicated that:

Pupils also progress well from their own starting points. Analysis of progress of the pupils who achieve [working towards] and level 1 at KS1 shows an improvement of 6% achieving two levels in reading and 19% in writing by the end of KS2. (CS6 internal report for 2006/07)

Furthermore, the SEN manager reported that:

We have detailed data sets for SEN pupils—numbers below Key Stage thresholds, conversion rates across levels by the end of Key Stages.

Data were also available to LAs at school level including individual educational plans, annual reviews and data from individual assessments by SLTs, educational psychologists, teachers, and specialist teachers. However, these data sources varied both between LAs and within; for example, there was not necessarily an LA policy on specific measures to be used to provide information on pupils. A report made available by LA6 commented that there was:

variation in practice and lack of consistency regarding the overall remit of individual centres and their relationship to wider authority policy and support for other settings.

And referred to:

lack of consistency in assessment arrangements making it difficult, in some centres, to track individual progress and comparative progress. PIVATS [an assessment programme designed to measure pupil progress through the 'P' scales and up to National Curriculum Level 4], for example, is not used consistently across all centres.

There were also practical problems faced by LAs in setting up monitoring systems. CS2's SEN manager explained the LA's proposed system:

Table 3. Percentage of pupils with SLCD in the case study authorities gaining level 1 (grades A*-C) and level 2 (grades D-G) passes at 16 years of age in 2006

Local Authority	Eligible pupils with SLCD (%)	Any level, % one pass	Level 1, five passes (%)	Level 2, five passes (%)	Level 1 including English and Mathematics, five passes (%)	Level 2 including English and Mathematics, five passes (%)
CS1	95	85	61	9	53	1
CS2	15	93	50	-	50	1
CS3	25	88	71	-	67	1
CS4	40	77	56	-	51	1
CS5	35	100	91	24	88	1
CS6	-	-	-	0	-	0
England: SLCD pupils	2030	89	69	15	64	6
England: all pupils		97	91	57	88	44

Note: No data are provided by the DCSF where there is a cohort denominator of fewer than eleven pupils or fewer than six pupils in a percentage numerator.

Banded funding is allocated according to information provided by the school on the degree of need of the pupil. A programme to meet that need is drawn up, with clearly specified outcomes that should be achieved by the end of the period over which the allocation is made. The school is supposed to report back to the LA on the progress made by the pupil and if the period is more than a year there should be an annual return of progress made.

However, the project did not run smoothly and indeed had failed at the time of the interview.

This model was developed from 2006 and started in 2007. The system soon hit problems. First, many schools refused to complete monitoring forms, then the monitoring officer was made redundant, then we found the data base being used for SEN data could not be adapted to accept the monitoring data so a different system had to be set up. We hope that the system will be slowly accepted and data will build up.

Evaluation of cost-effectiveness, unsurprisingly, was almost non-existent as this requires evidence of effectiveness as a component of the analysis. However, one LA claimed in an internal report that:

The comprehensive use of data also enables the LA to effectively track outcomes for low attaining pupils against delegated budgets and to fulfil the statutory duty to monitor the effectiveness of provision through an established cycle of monitoring visits.

Although this is not described as a cost-effectiveness process it indicates that one LA was at least considering cost factors.

There was substantially less data available from SLTs and this could vary even within a PCT because of differences at the level of individual professionals' practice. Furthermore, there was a severe lack of data exchange across the sample. For example, CS3's SEN manager acknowledged the importance of SLTs' input but noted that there was no agreement between the LA and PCT on the use of data for monitoring: 'pooling databases with health is a long way off'.

In summary, LAs had access to substantial amounts of data but only a minority provided evidence of systematic attempts to use data to address specific issues of monitoring and the evaluation of provision. Speech and language therapy services lacked large scale data sets but had individual level data, although this was not consistent. Data that were collected mostly concerned educational and cognitive abilities and there was a lack of monitoring of other domains. Finally, there was a dearth of integrated data systems combining educational and health data, seriously limiting the development of monitoring and evaluation of provision for and the progress of pupils with SLCD.

Research and evaluation

There was evidence of a small number of specific evaluation studies, typically one-off examinations of particular initiatives by SLTs. For example, one case study through its SLT service reported engagement with a large scale study by the British Stammering Association to identify standards of service. In addition, CS2 and CS3 had commissioned independent evaluations of their provision of a training programme delivered by the SLT service. A pilot study monitoring the outcomes of interventions was carried out by CS4's SLT service and CS5's SLT service had evaluated therapy outcomes for two treatment regimes for children with phonological problems. These were relatively small scale studies but indicated the willingness of SLT services to engage in research. Regrettably, however, CS1's SLT manager reported that, following a recent revision of the job specification for SLTs in the PCT, the trust had removed research as an aspect of work SLTs could legitimately carry out.

Discussion

This study of six LAs and their associated PCTs was designed to explore whether there was evidence to support the development of policy for the effective and efficient use of resources in services for children and young people with speech, language and communication difficulties (SLCD). This initiative reflects the recent interest in the UK government in evidence-based policy development practice. Furthermore, the study's genesis also reflected the political importance attributed to developing effective services for the larger group of children with speech, language and communication needs.

The case studies were selected to represent a range of LAs and PCTs with the intention of identifying the range of practice available. The central theme running through the results is that of variation. However, this diversity is not a function of evidence of equally valid approaches, so allowing an informed choice. Rather, the differences identified reflect a range of other drivers.

First, the conceptualization and definition of the group of children and young people are contentious and unclear. The Bercow Review (Bercow 2008) deliberately took a broad perspective and considered the research concerning all young people with speech, language and communication needs. This decision reflected the desire to be inclusive and to focus on all those who have needs in the three, overlapping domains of primary and secondary language difficulties plus those associated with lack of opportunity linked to social disadvantage, described in the Introduction rather than a more specifically defined group

of children. Our study, by contrast, focused mainly on those with primary speech, language and communication difficulties (SLCD), although interviews included discussion of the wider group. Nevertheless, it was evident that professionals struggled with conceptual and definitional issues. This applied both to SLTs, a profession with a tradition of diagnostic approach to SLCD, and to education professionals (SEN managers, head teachers and heads of specialist provision) whose approach is grounded in needs rather than diagnostic categories.

An important area of contention in the earlier national study by Lindsay *et al.* (2002) was the relationship between children with primary language difficulties (specific language impairment/specific speech and language difficulties) and those with autistic spectrum disorder (ASD). That study identified increasing tensions, as more children with ASD were identified and were replacing children with SLI/SSLD in language resources (Dockrell *et al.* 2006, Lindsay *et al.* 2005b). Changes in definition/diagnosis were proposed by service managers and practitioners as an important reason for this increase (Williams *et al.* 2006). Further evidence for the 'diagnostic substitution' hypothesis has recently been provided by Bishop *et al.* (2008), following up adults identified originally as children with developmental language disorders rather than autism.

Hence, the relationships between primary language difficulties and ASD are scientifically, clinically and educationally in a process of change. It is not surprising that both LA and SLT managers and head teachers are unclear or have different views on how best to describe, diagnose or make provision for these young people. Consequently, it is important that any system of identification and intervention focuses on research, influenced by any appropriate diagnosis, rather than be driven by a diagnostic approach which is fallible.

The second area examined concerns methods of meeting needs. The variety here reflected both the history in LAs and services of approaches to special/mainstream provision, current views on inclusion and the stage of development of collaboration between education and health services. LAs vary in their overall specialist provision in part because of their history of development of special schools and specialist integrated resources in mainstream. All LAs subscribed to inclusion as a major policy driver but their interpretation of the implications of this policy varied. This reflected the tension between ideology in terms of inclusion and children's rights compared with the reality of having to make decisions on real children on a daily basis. Although not describing the issue totally in these terms, senior LA and PCT staff were struggling to develop inclusion taking into account both children's

rights and evidence for efficacy (Dockrell and Lindsay 2008, Lindsay 2007). Consequently, LAs were developing different systems based on different formulations of mainstream and specialist provision. Given the variation in provision for SLCD across the LAs covered in this study it is not possible to draw general conclusions about how the nature and extent of segregated provision influences services for pupils with SLCD in resource provision in an integrated setting or in mainstream classes.

Third, there was relatively little evidence of collaboration between health and education services. A fundamental characteristic of children with SLCD is their having both educational and language needs. Recognition of the necessity for health and education to work together was highlighted in the earlier study by Law *et al.* (2000) and politically by the responses of governments in Wales and England at that time to support developments to improve collaboration (e.g. Welsh Assembly Government 2003). The limited development in this domain is particularly disappointing but supports recent evidence of the lack of collaboration, despite good intentions, between SLTs and educational psychologists (Palikara *et al.* 2007). However, one case study LA and PCT in the present study, in particular, had focused on this and had made substantial developments in terms of integrating the speech and language therapy service into schools. These new ways of service delivery were valued by schools, who were willing to fund more such provision from their own finances, so indicating its perceived success; however, no data were presented indicating benefits in terms of improved outcomes. At present, however, the development of effective collaborative practice between education and health services for children with SLCD is patchy at best, a situation highlighted nearly a decade ago by Law *et al.* The new requirements regarding the commissioning of services may stimulate more planned collaboration; if not, the picture could be even more negative in future. Positive developments are likely to require strong commitment and leadership from both the LA and PCT based on both a recognition of the importance of collaborative policy development, planning and practice and a mutual understanding of the contexts, conceptualizations and constraints pertaining to each service. Revised structures will also be required to allow effective implementation, which should include new ways of working among front line professionals.

Fourth, the use of monitoring and evaluation by LAs and PCTs was also varied and under-developed. In this case, the general situation was characterized by a high level of data being available to LAs but not to PCTs. However, LAs did not utilize this resource effectively nor had they developed a collaborative,

pooled database with PCT colleagues. The former reflects internal LA differences and, in particular, the organizational separation between data collection/analysis staff and policy-makers. The latter is more complex reflecting lack of systematic collection of appropriate data within PCTs; ethical concerns about data sharing although this need not prevent data sharing and joint analysis of specific data for specified purposes (for an example of such a positive initiative, see Rigby *et al.* 1999); and a lack of leadership to address this issue as a priority. In brief, they were generally not talking to each other to determine what questions they needed to ask and hence identify how data could be used intelligently. Yet, LAs are hugely data rich and these data are an excellent resource. For example, these data can be used for monitoring schools, to examine standards and to examine patterns of SEN (Strand and Lindsay 2009, in press). The lack of effective use of available data has also seriously limited the examination of cost-effectiveness of services. LAs and PCTs could usefully develop collaboration to think constructively about what they need to know to plan their service effectively and determine their data collection, sharing and analysis requirements accordingly.

More positively, there were a number of examples of local evaluations of service delivery. Such initiatives can provide useful information and complement larger scale studies by researchers in universities, for example. Potentially there is even more to be gained from collaboration between these two approaches. This field is particularly ripe for such development as both SLTs and educational psychologists have research training and experience. Furthermore, the development of doctoral level training and postgraduate doctorates in educational psychology provide a substantial resource for local research.

Conclusions

Addressing the needs of children and young people with speech, language and communication as their primary or secondary need has achieved high political prominence in England and, following the publication of the Bercow Review (Bercow 2008), the government is allocating additional resources (DCSF and DOH 2008). However, the present study has indicated the lack of a common, agreed approach to children and young people with SLCD as their primary area of need. This situation reflects scientific and conceptual challenges concerning the nature of these children's problems and a lack of development of effective collaborative practice between LAs and PCTs. This relative lack of development over the past decade is disappointing. The nature of these children's difficulties requires that LAs and PCTs collaborate

effectively to meet their needs. To achieve a systemic change across all LAs and PCTs is likely to require a major government initiative: leaving this to a 'natural evolution' has so far been ineffective. The Bercow Review provides a timely stimulus to such an endeavour.

Notes

1. See <http://www.naa.org.uk/efsa> (accessed 1 September 2008).
2. What Works Clearinghouse (<http://www.ies.ed.gov/ncee/wwc>).
3. See http://www.dfes.gov.uk/publications/childrensplan/downloads/The_Childrens_Plan.pdf (accessed on 1 September 2008).
4. These data concern pupils with SLCD as a primary need, although the DCSF terminology is speech, language and communication needs (SLCN). Consequently, they exclude pupils designated as having other primary needs, e.g. hearing impairment.

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Appendix A: Interview schedule: Local Authority level—policy level (for a senior SEN manager)

Name of Authority -----
 Name and title of interviewee -----
 Name of interviewer(s) -----
 Date of interview -----

1. What is your LA's approach to meeting the needs of children and young people (CYP) with SEN?
2. Who are the CYP with speech, language and communication difficulties (SLCD)?
3. What provision is there for CYP with SLCD?
4. What is the strategic approach to policy for CYP with SLCD?
5. To what extent does the service work on:

General professional development on SLCD and appropriate interventions

Specific help with curriculum/scheme of work development

In terms of the latter, is this more likely in 'speech language and communication friendly' schools?

6. What monitoring of provision takes place?
7. What data do you have at the individual level to monitor change (improvement)? Is there authority wide agreement or left to individual schools/units? Any agreement between LA and Primary Care Trust (PCT) about these issues?
8. Have you undertaken any evaluation of *intervention*?
9. What do you see as the main tensions in the system between LA/schools/PCT with respect to policy development/identification of CYP with SLCD/interventions/evaluation of provision?
10. Any other issues you would like to raise?

Appendix B: Index of Collaboration—speech and language therapy manager version

A. Joint strategic planning between SLT and education; inclusion

1. Do you meet with the LA manager with responsibility for SEN/speech and language therapy services manager to develop a joint approach for SLT provision to education?
2. Do the outcomes of these meetings contribute to any formal development plan within the LA?
3. Do the outcomes of these meetings contribute to the SLT service's development plan?
4. Are you developing a joint strategy with the SLT service/LA with regard to the inclusion of children with speech, language and/or communication needs into mainstream settings?

B. Service development at practitioner level

5. Do speech and language therapists and key education staff (e.g. Educational Psychologists, learning support services) take part in joint meetings/working groups, e.g. to discuss policy, develop criteria, etc?

C. Operational issues

6. Are quality assurance mechanisms in place for the review and monitoring of the impacts of SLT provision to children in educational settings (e.g. SLT outcome measures, progress with IEP targets, movement up/down the SEN register)?
7. Is the SLT service represented on the SEN placement panel (or equivalent)?

D. Continuing professional development

8. Do SLTs and educational personnel receive joint training on issues of common interest e.g. IEPs, literacy how, etc?
9. Do SLTs contribute to the planning and/or delivery of CPD provided to education staff (e.g. teachers, classroom assistants, learning support assistants)?
10. Do education staff (e.g. educational psychologists, specialist teachers etc.) contribute to CPD provided to SLTs?