Include us out? Speech and language therapists' prioritization in mainstream schools

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Abstract

Speech and language therapy services face tensions when prioritizing in an increasingly inclusive educational system. The selection parameters available for prioritizing children are discussed, and they appear to have limits in a mainstream school context. However, prioritization must continue for resource reasons, and ways forward are discussed.

Introduction

This paper examines the difficulties of deciding which school-aged children in mainstream schools should be considered for speech and language therapy (SLT) services. It argues that there are real tensions in attempting to operate a prioritization system (which becomes a selection system) in an increasingly inclusive educational context, and that prioritization measures are being used to restrict service delivery to schools before effectiveness studies have been carried out, or even where effectiveness studies suggest that SLT input could be beneficial to children. The justification for prioritization is the limited resource available to provide SLT, and it is an understandable response to resource constraints by individual services. The aggregate effect, however, may be to place SLT services to schools nationwide on an insufficient footing. The issues that must be addressed are listed.

The concept of prioritization

Prioritization of the paediatric caseload – deciding which children should

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receive services – is a recognized fact of SLT service provision (RCSLT, 1996). In the UK, speech and language therapists (SLTs) work within the national health service (NHS), employed by NHS trusts. They supply services to all sectors of the population, including children in schools. They therefore work in an NHS context, which selects appropriate children for services and assumes that such children can be differentiated from the normal population – the notion of 'caseness'. Prioritization is frequently discussed in relation to pre-school children, where maturational development means that some of the children referred will be found not to need SLT services. It often involves experienced clinicians making decisions in the relative absence of clear prognostic assessments, balancing a variety of child factors against the support offered in a child's communication environment (Pickstone, 1997; Roulstone, 1997).

Such active management of a caseload is designed to offer a fair and equitable provision of services based on need. Prioritization schemes mean that decisions on who is to be referred and treated can be explained to purchasers, users of the service and families (Portch, 1999). Prioritization therefore has the benefit of opening decision-making to public account (and, of course, to public challenge) and decisions can be codified into referral criteria, suggesting what would constitute an 'appropriate' referral. Prioritization decisions are set in the NHS context of clinical governance, a quality management system where treatment is to be offered based on evidence of effectiveness, and where audits of outcomes are undertaken to ensure that children are not subjected to inappropriate therapy practices and that public money is not wasted (DOH, 1997).

Priority for service has to be balanced against the amount of service available. In this context, deciding which referrals to encourage and which children to select for treatment is a form of resource allocation, or rationing (van der Gaag *et al*., 1999). If SLT services are highly stretched, prioritization means the selection of children to receive service, with lower priority children left until their problems resolve without therapy or become more pressing, or until more resources are available. If there are no prospects of increased resources, many children will never receive SLT services.

Prioritization decisions are difficult to make in pre-school settings, but are perhaps even more difficult in schools, where children's language and communication difficulties can be well established and less likely to disappear, although they can reduce, or commute into literacy or emotional and behavioural difficulties (Davidson and Howlin, 1997; Clegg *et al*., 1999). Prioritization by SLT services must nevertheless take place,

as demand for SLT services continues to outstrip supply. The concept of prioritization in mainstream schools will be examined, first in relation to educational philosophies and then in relation to the usefulness of prioritization parameters.

Prioritization versus inclusion

The contrast between health as a prioritizing service and education as an allocating service, which all children receive as a right, is discussed by McCartney and van der Gaag (1996) and McCartney (1999a). Recent educational legislation has stressed the need for high quality provision for all children, with each child receiving an excellent and appropriate educational experience (SOEID 1994, 1998; DfEE, 1997, 1998). This includes the right to receive at least 11 years of schooling (currently being extended as nursery places for all children become established), and a right to access their national curriculum, which has both oral and literary language and communication as main strands. Children also have a right to have their special educational needs met, irrespective of whether or not they have a completed statement or record of needs. Children have the right to such support as is needed to help them progress and education authorities have a duty to provide this. Parents' wishes have also to be taken into account, and parents have an important role to play in selecting a school.

Educational thinking has progressed further to accepting that a philosophy of social inclusion implies that most children will be educated in mainstream schools. Thomas (1997) outlines the case for mainstream schooling in terms of social justice, social value and social rights; arguing that an inclusive system is one in which children have a right to attend their community's school by default, rather than by demonstrating their 'readiness' to transfer into that setting. Such inclusive education requires careful differentiation of the classroom curriculum, and effective teaching styles must be employed (Knight, 1999).

There is general support across education authorities for the notion of educating children in the lest restrictive environment and for the need to refine and implement inclusive policies (Ainscow *et al*., 1999). Inclusion has cost implications that impinge upon education authorities' decision making, but they have an 'inalienable responsibility' to provide for children, and cannot fail to supply an appropriate education to an individual due to resource constraints or because of diverting resources to other parts of a service (Evans 1999).

Health service policies, which aim to prioritize children to receive services, are not easy to accommodate within this context. Where the aim is for all children to receive an appropriate education in their local school, the question of which children are to receive services to help them learn language should not arise. The notion of equal access to mainstream schools with a curriculum differentiated as necessary differs from the notion of selecting those deemed sufficiently 'pathological' to receive service, which is the health service model SLTs are being required to operate. In education, prioritizing due to resource constraints is not acceptable.

Inclusive educational philosophies are not, however, difficult to accommodate in SLTs' models of language learning. SLTs happily accept the language and communication benefits for many children of being in a mainstream milieu, which can:

> . . . benefit many students in the classroom, increase the amount of time students with [difficulties] spend in direct learning with peers, and facilitate their membership in a general education classroom, thereby increasing opportunities for them to practice and apply the products of learning in a meaningful and interactive manner'. (Bashir *et al*., 1998).

SLTs have also adapted to move their services into schools and accepted the need to work in cross-disciplinary teams and in close collaboration with teachers (RCSLT, 1998a; McCartney, 1999b), developing innovative approaches to work within mainstream contexts in partnership with education services (Roux, 1999).

The remaining difficulty is with the allocation of sufficient therapy resources. This was the only reservation expressed by the Royal College of Speech and Language Therapists (RCSLT) when commenting upon inclusive educational policies. The RCSLT supported the principles of inclusive education but highlighted the costs to SLT services that increasing mainstream inclusion brings. They noted that:

> Where children are focused within one special school, SLTs can concentrate their resources both in terms of contact with the individual children and in terms of teaching staff so that the provision of appropriate communication environments becomes more feasible. To spread the same children throughout geographically distant mainstream schools places considerable strains on the resources and organisation of SLT services. (RCSLT, 1998b).

This comment is in no way an argument against inclusion or collaboration, but a practical point about resources. From an SLT's point of view the tension between prioritization and inclusion does not come down to a clash of philosophy but to a matter of providing for a recognizably expensive form of education. SLT services operating with

resource constraints and low staffing levels are driven towards prioritization policies, which are transparent and fair, but which act to restrict the service offered. Low priority children who do not meet the service-delivery threshold are unlikely ever to get SLT services.

Prioritization parameters

Prioritization, and indeed selection, is less worrying if parameters can be drawn which mean that the 'right' children – those who can benefit – are selected for service, and children excluded who would not have benefited: the sensitivity and specificity issues associated with all screening services. Prioritization parameters will be reviewed, to see how they affect service allocation decisions in schools. Some parameters are common in clinical decision making and have general application (RCSLT, 1996). Some have been applied mainly to pre-school settings and a few have been built in to provision for children with special needs. Parameters are not typically associated with validated assessment procedures, but allow a large element of subjectivity and clinical judgement (van der Gaag *et al*., 1999). A search of the SLT prioritization literature reveals the following parameters for prioritization:

- the *severity* of a problem (Portch, 1999; Roulstone, 1995; Sisson *et al*., 1994), with triage as a particular way of operating with severity judgements (Pickstone, 1997);
- the predicted *permanency* or chronicity of a problem, related to a child's underlying disability and the SLT's knowledge of the natural history of language and communication disorders and the effectiveness of intervention (RCSLT, 1996; Pickstone, 1997; Roulstone, 1997);
- *age*, with a preference for dealing with difficulties as early as possible (Roulstone, 1997);
- the need for *techniques specific to SLTs* (Sisson *et al*., 1994);
- decisions on how well a *child's communication environment* is currently meeting their needs, and on how anxious carers (and by extension teachers) are and how willing to co-operate (Roulstone, 1995; RCSLT, 1996; Portch, 1999);
- '*readiness*' for therapy (Sissons *et al*., 1994; Roulstone, 1995; Pickstone, 1997; Portch, 1999), where a child is perceived as being able to benefit from intervention in the immediate future, related to the commitment and *motivation* of the child (RCSLT, 1996).

Parameters interact in decision making, and can be further arranged into a decision tree, with some factors more highly weighted than others in selecting children for service. This makes prioritization a complex business, demanding clinical skill and experience, as well as a set of guidelines. Prioritization parameters were not designed for mainstream schools: however, they cover many of the issues SLTs would expect to take into account, and it is worth considering each parameter in turn to scrutinize its potential usefulness in building valid prioritization procedures for mainstream schools.

Severity

Severity is a parameter affecting most prioritization decisions and it is used in conjunction with other factors. It is built into educational decisions about the opening of a statement or record of special educational needs, with normative statements about the percentage of children who are expected to require such a document – around 'the bottom' 2% (DfEE, 1997). SLTs have a role to play in the opening of a statement or record, but are committed to the concept that the vast majority of children with difficulties who do not require a full record or statement should also be able to access SLT services easily (RCSLT, 1998b). For non-recorded/statemented children, severity judgements become difficult to sustain. There are two problems – any severity cut-off point is inevitably arbitrary, and severity scores exclude children with mild difficulties who would nonetheless benefit from therapy. For example, many schools and parents are dismayed to discover that children with mild but noticeable speech distortions may never receive the help they need to change. Severity cut-off points provide a way of coping with excess pressure on SLT services, but their educational or therapeutic value is difficult to sustain.

Permanency

SLTs are likely to predict how permanent a child's language and communication difficulty will be on the basis of the child's history, underlying disability or pathology, and changes reported in the literature. Schools are less likely to work with this medical model, and indeed may be averse to such an approach as inappropriately 'labelling' children (Norwich, 1999). Categories can be seen as a threat to inclusive

education by stressing the child's deficiencies and by undervaluing individual variation. Schools are committed instead to a regular cycle of updating information on a child's current skills and difficulties and to tailoring language-learning experiences appropriately. Models of good practice in meeting special needs stress the need for such reviews and allow for children to receive more or less support for their learning, according to need.

If SLTs on the other hand have expectations of language change common to clinical categories, they may anticipate that language problems will ameliorate or plateau over time. This can lead to SLT services planning to remove input as children progress through school, even though language problems remain, and can curtail the opportunity for detailed consideration of an individual child. Such restriction of service based on expected patterns of change fits badly with educational thinking and can cause problems in providing services for individual children.

Age

The parameter of age is clearly linked to the parameter of permanence, and appears to be a powerful variable in selecting children for service. There is a very limited SLT service to secondary children, particularly those educated in mainstream schools (Reid *et al*., 1996) and many language units in mainstream schools that have good SLT input only provide placements during the early primary years (MacKay and Anderson, 1999). This may be an artefact of the early intervention policies of both health and education services, and a lack of awareness of language impairments in later primary and secondary education may limit referrals. There are also problems for SLTs in liaising with the large number of teachers involved in secondary schools.

The result is that older school children tend not to be in receipt of therapy services, but age in itself is not a particularly good indicator of language learning needs. Academic problems throughout the school years have long been associated with language problems (Wiig, 1986) and school presents increased language challenges to pupils as they get older, particularly if literacy and the executive functions of planning and controlling are included within language skills (Apel, 1999). SLTs can be key individuals in supporting older language-impaired children who require to cope with the language demands of the curriculum (Culatta *et al*., 1998) and bring an approach to language learning that complements

that of learning support teachers. In the school context, there appears to be no educational reason for restricting the services offered to older children.

SLT – specific techniques

SLTs prioritize children in relation to their need for the specific skills and techniques associated with SLT practitioners. These would include expertise in augmentative and alternative communication systems, in dysphagia, and in aspects of language such as phonology and syntax development, of which classroom teachers have limited knowledge.

It seems appropriate to prioritize children who can be helped principally by SLTs. However, SLTs have a further range of skills and knowledge, which could be capitalized upon. The development of literacy is increasingly being seen as based on language abilities: for example, aspects of phonological awareness and knowledge of narrative structures contribute to success. SLTs have expertise across language areas and can make specific contributions to educational programmes for children (Gillon and Dodd, 1997). Such developments are currently restricted, with hard-pressed SLT services avoiding, or at best restricting, SLT involvement in the teaching of reading, for fear of being overwhelmed by a deluge of referrals (Gorrie *et al*., 1998). Once again this is a resource constraint, not an educational or therapeutic rationale for selecting children.

A sub-set of issues around SLT-specific expertise is the notion of working with certain populations of children, and not others. A compelling example is that of entry to language units in mainstream schools, where a considerable amount of SLT input to school children is focused. Children are typically selected for language unit attendance on the basis of a discrepancy between severe language difficulties and relatively good non-verbal cognitive abilities (Conti-Ramsden and Botting, 1999). However, such cognitive referencing is a poor selection parameter, for two reasons. Discrepancy scores may not be particularly reliable, and may be over-restrictive: Bishop (1997) cautions against the use of such criteria to decide who should receive help. Furthermore, the limited number of studies of children with no cognitive discrepancy suggest that they respond as well or even better to intervention than classic language disordered children (Cole *et al*., 1999) This suggest that extending services to children whose cognitive difficulties are in line with their language difficulties could be

useful. The overall point is that the specific expertise of the SLT is not being used to the full, and that effectiveness studies suggest that there are other populations of children who might be well served by access to SLT input.

Communication environment

Many SLTs dealing with pre-school children attempt to assess the responsiveness of the child's home and nursery environment to the child's emerging communicative needs, and build this into their prioritization decisions (Roulstone, 1997). Schools have trained teachers who have studied how to develop language use and should not provide impoverished language environments. Nonetheless, schools in general make different language demands from homes (MacLure and French, 1981) and provide a variety of language environments. Classes can vary in how explicit they make the 'ground rules' for participation in classroom talk, and teacher talk (at least in formal lessons) becomes more complex as children proceed through school (Sturm and Nelson, 1997). There could well be a mismatch between a child's language skills and the demands of their classroom environment, and in such cases the communication environment of the classroom might be considered and ways of producing a more facilitative interaction pattern developed. This would be a complex undertaking in the school environment (Scott, 1994; Kovarsy and Damico, 1997) but consideration of the school child's communication environment could become a factor in prioritization.

At present, however, it is unlikely that SLTs in the UK have an opportunity to make such judgements. They do not assess individual classrooms, although they may offer inservice programmes for teachers, which suggest general principles of helpful teacher talk. If the communication environment is not evaluated, it cannot feature as a prioritization parameter, and although it could be a useful addition to the list, it does not appear at present to be as widespread in a school setting as it is pre-school.

Readiness and motivation

'Readiness' is where a child is assessed as being able to benefit from specific therapy input in the immediate future. Roulstone (1995) lists

'child's ability to cope with therapy' as among the 10 most important factors taken into account by SLTs working with pre-school children, and as one of the factors used to signal prioritization. It is often used pre-school in cyclic approaches, where a child receives therapy input for a period and then has a break, or where regular reviews determine when therapy should start. It is associated with notions of maturity and response to stimulation and may involve probes and experimental teaching sessions which determine whether a child can cope with direct language work.

Roulstone (1995) also lists child motivation as a prioritizing factor, although less powerful than readiness. It appears to be another potentially important parameter, and could be particularly useful with school-age children. With young children, decisions about intervention may be guided by parents' motivation rather than children's, whereas with adult clients a personal motivation to change may be required before therapy begins. School children are in the middle of this transfer of responsibility, but may themselves become able to decide when they need therapy support and what gains they would like to make.

Readiness and motivation appear to have the potential to become a sensitive prioritization parameter, which would overcome some of the problems of using less child-specific factors such as age and permanency. Unfortunately, there is little information about what SLTs actually do to determine readiness or motivation and it will presumably vary from child to child. Decisions about these factors may be too embedded in clinical decision making to become a public, accountable measure of selection for service, but if the essence of the parameter could be teased out it might be useful in deciding when children received services during their school lives, and when it would be safe to take a break.

Discussion

The parameters used to prioritize services to young children, and to select who will receive service, do not seem particularly suited to mainstream school children, and so decision-making based upon their interaction would be difficult. Some appear to exclude children who might benefit from service and to have a limited educational and therapeutic rationale in a school context: others are underspecified. Services are, however, driven into prioritization by resource and staffing limits. In setting out and publicizing their decisions, they are adopting an honourable position,

explaining what they are doing with the scarce resources available and how they are making sincere attempts to share equitably and target service to children who need it and can benefit (Rice, 1998). The difficulty is that they are also having to *exclude* school children who most probably need SLT service and could benefit.

There is a paucity of effectiveness research into SLT practices in schools, particularly of random control trials (Law *et al*., 1998) and a difficulty in sorting out the differential contribution SLTs make to the whole educational process (McCartney, 1999c). However, the work that has been published (RCSLT, 1998a) suggests that on the whole SLT intervention is useful (and indeed the research is arguably more thorough than empirical research on the benefits of inclusion (Feiler and Gibson, 1999; Hornby, 1999). But evidence for therapy effectiveness can only be gained by examining the work carried out, and at present it appears that SLTs may be restricting their provision and excluding children prematurely from service. The question of effectiveness therefore remains open for these excluded children, although as cited some research studies suggest potential benefits.

Managing the situation

There appears to be much work to do before valid prioritization methods can be put in place. There is a danger that over the UK the aggregate effect of current prioritization policies is detrimental to a number of children. However, SLT resources are limited and will not be sufficient to offer services to all in the short term. There are a number of issues that SLT managers and professional advisory bodies could take forward to explain the situation, and perhaps ameliorate it.

It would help to discuss the reasons behind prioritization. This paper has argued that the need to prioritize may in the first place be due to resource limits, and if true this fact should be explained by services. Unless children are harmed by SLT attention or public money is wasted on ineffective therapy, service should be delivered and a detailed needs assessment should not automatically exclude children based on current prioritisation procedure. If managers are then hindered in offering therapy by resource limits, they should say so.

There is a need to make clear which prioritization parameters are operating in an individual service. There are a variety of decision making

procedures available, and purchasers, users and staff of a service would benefit by knowing which ones apply to their local situation.

There is a need to develop realistic planning mechanisms, which take account of demand for service provision in schools and quantify how many therapists would be needed to supply it (McCartney, 1999c). It is probable that such planning would suggest a further increase in SLT staff, and further decisions on how SLT services in schools are to be funded.

It would be helpful to consider the question of the effectiveness of SLT input for school children who tend currently to be excluded from service, such as older children, children with literacy impairments following resolved speech problems and children with moderate cognitive difficulty. There is a need for experimental projects which evaluate intervention with such groups and which would serve as a benchmark for standards of service. SLT services may be reluctant to embark on such projects as there is a danger of increasing demands for service, which cannot be met. Nevertheless, the issue of effectiveness should be explored so that educationally and therapeutically valid decisions can be made.

The prioritization parameter of 'readiness' for intervention looks potentially useful, but is not sufficiently well articulated at present to be reliable. Qualitative research in schools of the type carried out by Roulstone (1997) on therapists' decision making processes might help to tease out this construct, and to test its utility as a prioritization parameter.

Conclusion

SLTs and educationalists want all children to flourish in classrooms and want children with special needs to have an inclusive education within an inclusive society. Therapy services have adopted commonsense parameters to prioritize children, which are fair and which have been employed with pre-school children, but which do not appear on scrutiny to work very well for mainstream school children. There are problems in fitting such SLT selection procedures into educational thinking, which can damage collaborative work and set up tensions between services in school settings, especially where prioritization policies appear to be driven by resource limits, rather than educational or therapy considerations. This is not a satisfactory situation, and as professions seek to develop joint approaches to service delivery there will have to be systematic exploration of ways in which to 'include us in'.

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