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SPEECH AND LANGUAGE THERAPY SERVICES FOR CHILDREN

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EXECUTIVE SUMMARY

This research was commissioned by the Department for Education and Employment and the Department of Health to identify, describe and evaluate the key models of collaborative organisation and delivery of efficient and cost-effective speech and language therapy services to children. The study was undertaken in five areas across England and interviews were conducted with a variety of staff involved with the speech and language therapy service. These were therapists and assistants, classroom teachers and assistants, support teachers, educational psychologists, headteachers, purchasers, senior NHS Trust personnel and education advisers. Parents in three of the areas were also invited to contribute their views and experiences. It is important to note the very positive response to this research in the field. All those approached for interview responded helpfully and constructively to the questions they were asked and provided many insights into the practice and potential of collaborative work.

This study was concerned with very complex and diverse roles and responsibilities. It was conducted at a time of considerable change within both the health and education services. Not surprisingly, those taking part elaborated on the challenges of service delivery and the constraints they were subject to as they sought to develop constructive working relationships with colleagues from other services. What was abundantly clear, however, was the commitment to collaborative ventures that exists and the considerable efforts being made to enhance joint enterprises.

Looking at the continuum of collaborative possibilities, this research identified examples of liaison and joint working practices that were well-established and generally regarded to be effective. There were also examples of joint planning and discussion and establishing and developing services, although these were often in an embryonic stage. The highly developed collaborative practices *vis-à-vis* commissioning were not yet evident at this stage. Such practices will require complex and sophisticated systems to formalise accountability.

At the level of service planning and policy-making, it was evident that collaboration was seen as the way forward and that the senior personnel involved were eager to encourage joint developments. Working relationships were said to be constructive. Some initiatives at grass-roots level, notably speech and language groups established in schools and speech and language training for classroom assistants, were universally applauded as effective and efficient systems for reaching children who would benefit from that help.

Some of the features of the speech and language groups in schools highlight positive practice for the development of collaboration. This work was characterised by:

- broad consultation during the planning stages
- funding and a firm commitment from the education department
- a cautious approach involving careful piloting, monitoring and evaluation
- the involvement of experienced therapists with well-developed inter-personal skills.

The various training courses run by therapists for education staff were widely regarded as well-targeted and professionally delivered. As stated, those enabling classroom assistants to develop their skills were particularly commended. Joint initiatives such as language panels, where staff from different services worked together, facilitated the establishment of referral systems that were clearly understood and negotiable. They provided a springboard for other collaborative ventures and a vehicle for the effective dissemination of suggested practices and policies across professional groups.

Some general points arising from this research were:

- Collaborative multi-agency and multi-professional work is not easy to achieve. That so much constructive collaboration was identified in this study is noteworthy.
- The value of systems for developing collaborative practice was evident from the arrangements studied here. A coherent approach to developing joint working is required and, in common with other professional groups of health and education providers, those involved with speech and language therapy have established much good collaborative practice and are seeking to develop further structures and schemes.
- It was evident that health and education personnel were largely uninformed about each other's management structures and constraints.
- Scope for improving channels of communication at all levels was identified. There were gaps in information across all sectors about who provided what and how services could be developed. An essential backdrop to any negotiation was a comprehensive information base and there was general agreement that this should be strengthened.

Overall, the views on and experiences of collaboration were optimistic in tone, clarifying both the current situation and the way forward. It is encouraging that, without exception, all those taking part in this research believed the collaboration they had taken part in to have been productive and beneficial, and this report records some of these achievements. Respondents were aiming for a seamless service for clients, so that professional and territorial boundaries would not affect adversely the delivery of support, nor indeed be obvious to recipients. The goal was for the best use of resources, irrespective of which agencies that might involve.

In this study, data were collected from a variety of people about the collaboration they were involved in, providing an opportunity for them to put on record, for discussion and debate, how they are working, how they wish to proceed and factors that influence the way forward. Documenting in this way some of the key issues in the delivery of collaborative speech and language therapy services to children, from a variety of perspectives, provides a basis for the further discussion and development of good practices. It is anticipated that such information will be useful to staff in both education and health who wish to develop their current provision for children with speech and language difficulties.

ABBREVIATIONS

AFASIC	Association for All Speech Impaired Children
CLEA	Council of Local Education Authorities
COP	Code of Practice on the Identification and Assessment of Special Educational Needs
CMO	Clinical Medical Officer
DfEE	Department for Education and Employment
DOH	Department of Health
GP	General Practitioner
GPFH	General Practitioner Fund Holding
HV	Health Visitor
IEP	Individual Education Plan
LEA	Local Education Authority
LMS	Local Management of Schools
NHS	National Health Service
OFSTED	Office for Standards in Education
RCSLT	Royal College of Speech and Language Therapists
RHA	Regional Health Authority
SENCO	Special Educational Needs Coordinator
TASLTM	The Association of Speech and Language Therapy Managers
WTE	Whole-time Equivalent

1. BACKGROUND

THE CONTEXT

Since the publication of the Court Report (1976) and the Warnock Report (1978), there have been a large number of statutory rulings and guidelines reinforcing the importance of inter-agency collaboration in respect of services for children, particularly children with special educational needs. Both the 1981 (GB. STATUTES, 1981) and the 1993 (GB. STATUTES, 1993) Education Acts stress the importance of this collaboration, and the Code of Practice on the Identification and Assessment of Special Educational Needs (GB. DFE, 1994) states that: 'If effective provision is to be made for children with special educational needs it is essential that schools, LEAs, the health services, voluntary organisations and other agencies work very closely with each other, and that all work closely with parents.' However, unlike the Children Act (GB. STATUTES, 1989), which requires local health, education and social services to cooperate and communicate with each other in the area of child protection, legislation has stopped short of making such inter-agency collaboration mandatory in the area of special educational needs.

There is some evidence that such collaboration is often weak and fragmented, Maychell and Bradley (1991), and tends to rely on the commitment of individuals rather than being part of an essential infrastructure of support. Maychell and Bradley (op. cit.) looked at collaboration between the education, health and social services and found that while there were significant elements of good practice associated with all of the initiatives, none had succeeded in achieving its overall objective of embedding new working practices in the system as a whole.

Changes in the funding arrangements within the health and education services are encouraging innovative arrangements for the delivery of speech and language therapy, although the profession itself (RCSLT) maintains that provision should continue to be organised from within the NHS. It is noteworthy that the RCSLT organised a policy review forum in 1993 to debate issues raised by the membership in relation to collaboration with education. However, while collaboration has been on the agenda for some time, very little has been documented. Few practitioners have sought a wider audience for the discussion of their practice and aims. Those that have (e.g. Ackerman and Bell, 1994 and Cooper *et al.*, 1994) tend to write for their own professional publication, although Carr and Smith (1992) and Fleming *et al.* (1994) have published in the special educational needs literature.

The current study seeks to widen the debate, partly by documenting evidence from five sites across England, and partly by making it

available to any of the various groups involved in speech and language therapy delivery. There was widespread agreement on the need to present an overview of the issues in collaboration and several respondents expressed interest in knowing how colleagues felt about the issues under scrutiny.

SPEECH AND LANGUAGE THERAPY SERVICES FOR CHILDREN

For the last 20 years speech and language therapy has been organised and delivered within the context of the NHS, largely as a result of the recommendations of the Quirk Report (1972). The NHS remains the major employer. Most therapy services for children are based within Community Health Trusts, and form part of an integrated local service incorporating other therapy teams for adults and, commonly, people with learning disabilities. Funding arrangements, although changing, tend to include the local health commission as main purchaser.

Most speech and language therapy services operate an open referral system, although commonly the majority of those referred are pre-schoolers identified by health visitors. The service is provided in a variety of locations, depending on local needs, and including clients' homes as well as hospitals, community clinics, health centres, day nurseries, and mainstream and special schools.

Staffing establishments vary considerably across the country. A ratio of six WTE speech and language therapists per 100,000 of the population was recommended in the Quirk Report (1972), recognised even at that time to be a significant underestimate of the need. Enderby and Davies (1989), for example, suggested a need for 26 WTE therapists per 100,000 based on current service delivery models. All services have a mix of therapy staff including those with particular specialties (e.g. severe language impairment, special needs, hearing impairment, dysfluency, physical disability, cleft palate, etc.), depending on local needs. In some cases they are supported by locally trained assistants, whose role varies from largely administrative and clerical duties to direct practice.

The forms of therapy offered also vary according to client group, local needs and other factors, and can range from regular, direct individual intervention to group work, classroom support, and more indirect support providing monitored programmes of work and advice. In recent years there has been a trend towards more indirect work and more therapy being delivered within mainstream schools, partly as a result of the increasing integration of children with special educational needs into mainstream schools.

A growing awareness of speech and language difficulties and a corresponding increase in referral rates for therapy have come about in part as a result of educational developments, notably the 1981 Education Act (GB. STATUTES, 1981), and more recently the introduction of the National Curriculum and the Code of Practice (GB. DFE, 1994). A survey undertaken on behalf of CLEA (1994) showed that around half of the LEAs were experiencing difficulties in securing therapy services sufficient to meet the identified needs of pupils with statements. As the majority of children referred for therapy will not be statemented, the extent of the shortfall may well be greater than this. Services are having to re-examine therapy methods and the ways in which provision is organised and managed.

COLLABORATION BETWEEN THERAPISTS AND EDUCATION STAFF

Therapists have long recognised the importance of collaboration within an educational establishment, noting that therapy is most effective as an integral part of the child's school life and 'should be jointly planned to fit in with the child's overall education programme and address issues currently significant in the child's educational life' (RCSLT, 1990). The acceptance of therapy as 'educational provision', after all (Addendum to Circular 22/89, GB. DES and DOH, 1992), implies more than a relationship of simple addition between therapy and education. Despite these statements, Wright's research (1992) found little evidence of much close collaboration.

There are reports (e.g. Lesser and Hassip, 1986) of a very significant mismatch between the ways in which therapists and teachers see their roles. There are obvious differences in philosophy, training, and employment conditions. Therapists work within a medical model, planning their own remediation programmes with a specific focus on communication, whereas teachers have an educational model, with responsibility for the whole curriculum. Where therapists often work in isolation, in several settings each week, teachers are members of a single-site team. Generally, therapists will have responsibility for a larger number of children, often over a longer period of time.

The RCSLT, through its Education Working Party, published guidelines for teachers and therapists working together (RCSLT 1992) which recommended that speech and language therapy managers liaise with divisional special education inspectors to arrange joint courses, because: 'Maximum benefits may be gained from such courses when speech and language therapists and teachers attend together; a common experience and shared basis of knowledge can

often promote great cooperation and professional understanding.' As Wedell (1990) said: 'There is little doubt that professional training is remiss in failing to prepare members for the demands of cooperation and to provide members with the necessary information about other professions offering complementary skills and knowledge.' Some attempts have been made to address this training need at both postgraduate and undergraduate level (e.g. Sadler, 1991; Miller, 1991 and David and Smith, 1987).

Hart (1991), in examining collaborative work between class teachers and support teachers, suggested that it is unhelpful not to acknowledge the very real difficulties in establishing an effective working relationship with any situation 'because it sets up unrealistic expectations of what can be achieved, leading to dissatisfaction (and indeed stress) when practice always falls short of these ideals. It also delays the development of shared understanding which will enable us to prevent, resolve or work with them effectively.' Hart suggested that even those partnerships struggling in the least auspicious circumstances may reflect good practice if the members can justify decisions made in relation to the developmental possibilities available, such practice being flexible, self-critical and developmental.

Having outlined some of the background that needs to be considered when present-day collaborative work is discussed, the next section is concerned with the methodology adopted for this research. This consideration of the way in which the work was conducted is followed by information from the five sites where data were collected. There are details of the forms collaboration took and background details of the therapy services. The final section identifies some of the major issues in the development of positive practice to emerge from the study.

2. METHODOLOGY

THIS RESEARCH

The research was undertaken in five locations in England, which were all areas where it was said that there was a positive approach to developing various kinds of collaboration in the delivery of speech and language therapy. In the first phase of the project, a review of the relevant literature was undertaken and the major agencies with an interest in the field (RCSLT, CLEA, TASLTM, AFASIC and the DOH) were approached, with the aim of identifying issues in collaboration and nominations of services where there appeared to be collaborative practice between health and education. The final selection of five services was made by the project Steering Group from the shortlisted nominations, all of whom had expressed interest in the research.

A total of 139 staff and 42 parents took part in this research. The number of interviews on any one site depended, obviously, on the nature of the collaborative work undertaken. On one site, for example, where joint working practices and the joint establishment and development of services were in evidence, the interviews with the head of service and head of the children's service were followed by those with the following 24 staff.

- therapists running the intensive speech and language groups (2)
- learning support staff involved (2)
- the educational adviser (1)
- the educational psychologist (1)
- the headteachers whose schools took part (7)
- staff from some of these schools (8)
- a purchaser from the health authority (1)
- senior Trust personnel (2).

In each location the research commenced with a lengthy interview with the head of the speech and language therapy service and of the children's service, where applicable, and the names of further contacts were obtained. Most of the interviews were held with one contributor at a time and many were tape-recorded. Parents and some senior staff took part in telephone interviews. All the interviews were conducted on a confidential basis and anonymity was assured.

It was anticipated that such information would be useful to staff in both education and health who wish to develop their current arrangements for the education of pupils with speech and language difficulties. The study sought to identify, describe and evaluate some types of collaborative organisation and the delivery of efficient and cost-effective speech and language therapy services. This meant gathering information on the wide range of professional, organisational and financial issues affecting service delivery.

The findings from this research highlight issues of interest and concern to all those involved in the delivery of speech and language therapy services to children. The study provided an opportunity for these participants to relay their views and experiences. This report documents their perspectives and allows for further discussions of how progress can be made. This is not an analysis of the optimum way forward (the diverse and complex nature of collaborative practices would preclude that) but is information that may be useful in future decision-making and practice.

The main aim of the study was to learn from the experience of policy-makers and practitioners who have begun to explore the possibilities of collaborative working. While there is no such thing as a standard model of inter-professional collaboration there are a number of common features and experiences that can be identified. A wide variety of solutions to the challenges inherent in implementing collaborative working are continually being sought – often in isolation. This research focused on five case study locations which exemplify at least some of this diversity.

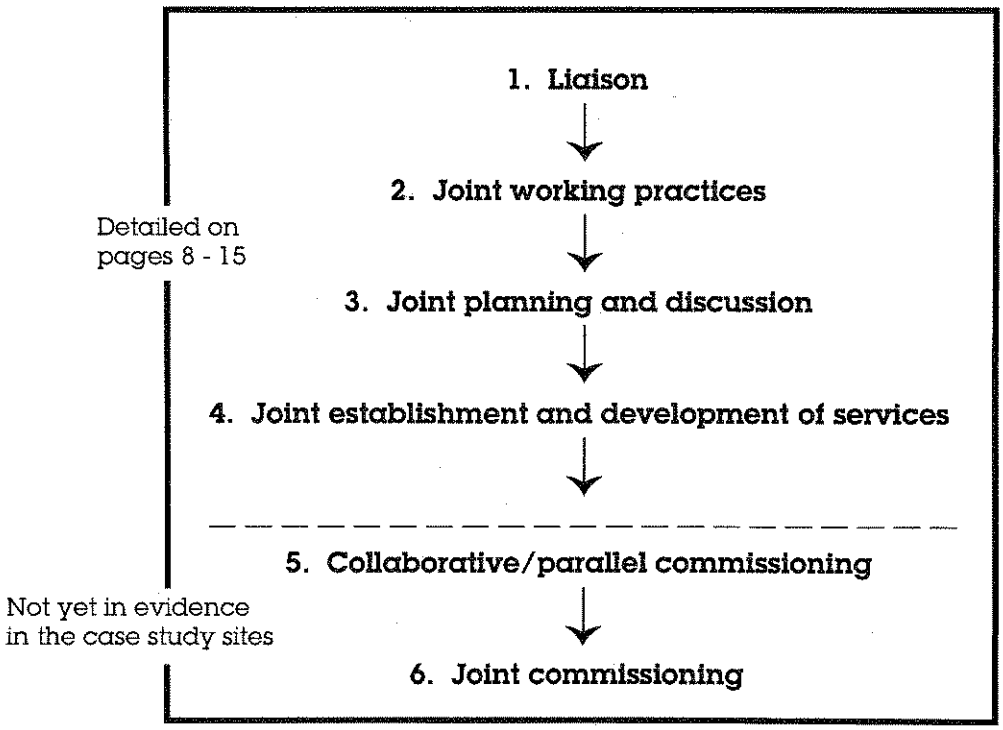
As stated, a large number of individuals took part in this research. In each interview the researcher listened attentively to the main ideas, themes and statements given by the respondent in response to each of a series of areas of inquiry. The questions asked varied, obviously, depending on the type of respondent. All staff were asked for brief details of their background and to describe their experience of collaboration with (as appropriate) either education or health personnel. They were asked for their views on the current situation and how they felt it would (and/or could) be developed. As appropriate, details of training provided and participants' views of it were collected. Parents were asked for brief details of their child(ren) and of their involvement with the speech and language therapy service. An overview of their experience of multi-agency collaborative work and views of it were sought. The aim of the questioning was to ascertain what collaboration respondents had been involved in and their perspectives on what was achievable and/or desirable.

3. COLLABORATIVE WORK IN PROGRESS

AN OVERVIEW

This section provides information about the collaborative work being undertaken and gives details of the speech and language therapy services that were the starting point in each of the five locations. The process of developing full collaborative working systems may be divided into six stages, as detailed in the chart that follows. The services studied in this research were working at stages 1, 2, 3 and 4. Further contacts between speech and language therapy and other services are detailed in the charts on pages 19 and 20.

Figure 1: Stages in collaboration



The four stages of collaborative work identified in this study covered a wide variety of practices. Liaison, for example, included outreach work for children transferring to mainstream settings, a joint working group (mainly therapists and teachers) designed to facilitate collaboration, twice-yearly screening for mainstream schools and the provision of training courses for teachers and classroom assistants. Joint working practices were incorporated into support provided in mainstream schools, either directly to pupils or in collaboration with their teachers, and also in the way therapists and education staff worked together in special provision. Intensive speech and language groups established in primary schools necessitated constructive joint working. Joint planning and discussion were in evidence in the language panel, initially established to coordinate the referral and

placement system, but now viewed as providing valuable opportunities for further joint developments and exchanges of expertise. This form of collaboration was also illustrated by the negotiations resulting in a mainstream support scheme. The more firmly rooted joint establishment and development of services were illustrated by the way in which the intensive speech and language groups in schools came on stream. This degree of collaboration was also evident in a community-based programme of parent education and support. Further details of each form of collaboration are provided below.

FORMS OF COLLABORATION

Liaison

♦ ***Outreach work for children transferring to mainstream***

Where outreach work was established to support children of seven years or more as they moved from language units to mainstream schools, the need was for time to plan and discuss those children's needs and progress. The therapists involved highlighted the value of that investment of time given that if children's potential to cope in mainstream was not realised they might eventually need classroom assistant support, which (for these children) was wasteful and counter-productive. At the age these children were being integrated the issue was of managing their access to the curriculum, and the therapist concerned felt that considerable progress could be made if effective channels for liaison could be established.

♦ ***Twice-yearly screening***

One speech and language therapy service's screening took place twice a year in all nurseries and mainstream schools – over a period of three weeks. This provided an opportunity for schools to identify children whose speech and language development was of concern and for the therapy service to pass on details of any pupils known to them. A 'contract' was then developed with the names of up to eight children and the therapist who would continue the work. Classroom assistants attended therapy sessions in school and then continued the programmes with pupils throughout the week. The success of this work depended on how effective this school follow-up was and how much time schools were able to devote to it. Therapists reported that the service had ceased in some areas because effective follow-up work in schools could not be provided. There was a tension for some schools because they wanted more direct therapy input and could not easily accommodate these new arrangements.

♦ ***Training courses for classroom assistants and teachers***

One chief therapist was awarded a one-year secondment, by the purchaser, to plan and implement training initiatives. The special educational needs adviser applauded this link, emphasising that

purchasers and providers both have strengths and weaknesses *vis-à-vis* collaboration and the challenge was to draw these together. Without relating well to both sides you were 'working in the dark'. He was enthusiastic about the courses therapists were running, enquiring 'How do we sustain them and other initiatives?'

Course content

These termly courses were costed at a nominal sum of £40, although some have been delivered free of charge. There was concern that because there were insufficient funds available for further training, individuals who it was felt could have benefited would not now be able to attend courses. The two-day course for approximately 20 teachers was run by one therapist and three therapists led the three-day one run for slightly larger groups of classroom assistants. The first day focused on normal communication and an overview of how it can go wrong, as well as information about how therapists work. There were then sessions on verbal comprehension, expressive language and the use of language, as well as speech clarity. The courses were responsive to the needs and experiences of those attending and there were opportunities to consider the difficulties of particular children they worked with as well as general strategies such as modelling.

Feedback from participants

One headteacher explained that her teaching staff who had undergone this training had been 'shattered, but delighted by the input. It straightened a few things up. Quite intense, quite high intellectual level, lots of information, needed to concentrate.' The three assistants from this school had found their course 'very useful' and the input had 'generally raised the quality of work with all children, particularly those with language problems'. Here, where having the training was seen as a way of tackling the problem of not having enough therapy hours, to lose the training contribution was felt as a double blow. Similarly, where assistants who had been trained had had to be made redundant (three individuals in one school), the wasted opportunity was keenly felt.

The headteachers of special schools on another site that had received training from the therapy service felt that it had been beneficial (although one felt this was more so for nursery nurses than teachers). They appreciated that such training had been provided mostly without charge and that no service input had been lost to the schools as a result. This 'extra' contribution was gratefully acknowledged. The most positive statements centred around the qualities of the therapy staff involved. One headteacher said that they were 'excellent ... carry high credibility'. School staff had been 'very impressed with the quality of the presentation and the theoretical nature'.

This commitment to training and liaison on the part of the therapy service was applauded. As one headteacher, whose perspective on the service had changed in recent times, explained, 'in the past they

(therapists) would come in and assess and go', whereas now the work was 'better focused' and the service was responding to needs as they were identified. Another headteacher, while appreciative of the courses, made the point that the training on a day-to-day basis was more effective. The approach whereby therapists did not withdraw children, but worked in the classrooms alongside other staff and were transferring skills in a continuing way was highly successful in her view. The only negative point about training concerned the rapid therapy staff turnover. In situations where schools had three therapists in two years it was difficult to maintain continuity and constructive working relationships.

The trainers' perspective

The therapists involved in the training found it to be very rewarding and worthwhile. The focus was on courses for classroom assistants, as these were the best established. It was emphasised that the assistants taking part were really keen and enthusiastic, often wanting to take on further reading and development work. Assuming that schools were able to allocate timetabled sessions for their work with individual children, this system for passing on specific skills and ideas worked well. One classroom assistant who had been working in tandem with therapists for 12 years had changed dramatically after the three-day course, with implications for her own development and her approach with the children. She had become aware, for example, of the purpose of some of the work on sounds she had been doing with children (for example, distinguishing between long and short sounds).

♦ *Joint working group (mainly therapists and teachers)*

A therapist and teacher working group had been established by therapists, as a response to the frustration staff felt about the lack of liaison time available. It was acknowledged that some schools were more able to facilitate liaison than others and the group provided an opportunity for staff to meet after school and work through issues raised by collaboration. It was held at 4 pm at a reasonably convenient clinic. Meetings were held termly as a group, with other subgroups tackling specific topics (e.g. speech and reading) in the interim. Support for the group has varied over time, but attendance is currently strong and members are keen to work out ways of informing others about the role of the therapists and how collaboration might work. The sessions were publicised in a variety of ways, most successfully by asking staff to hand out details personally.

Joint working practices

♦ *Intensive speech and language groups in seven schools*

Running the groups

The speech and language groups were established by a therapist and a language learning support teacher, who worked closely with teachers and classroom assistants from the start. They were run for six weeks

and then, after a six-week break, school staff continued with them. Up to eight children, selected by the therapists, took part in twice-weekly sessions. There were two such groups in each school. Parents were invited to school to discuss the aims and content of the groups and training was given to the staff in the participating schools.

Training

Sufficient time was required for training in the schools receiving this service, to alert staff to the therapists' and support teachers' work and its potential benefits. Teachers were expected to assess their pupils' speech and language development, using documentation provided by the therapists, and work on IEPs developed with them as a result of the groupwork. It is noteworthy that when training sessions were held after school it was unusual for classroom assistants, who have different conditions of service from teaching staff, to attend. Given the vital role they played in working with individual children, this was a cause for concern.

♦ *Work in specialist provision*

Children in the language provision in this service (five for nursery and one for primary age children) were those who had been identified either from involvement in the statementing process or by being brought to the attention of a pre-school panel. Each eight-place site received 0.4 of a therapist's time for assessment, intervention and programme planning, and 0.5 of a nursery assistant's time was provided by the education service. The aims were to share knowledge and skills between teaching staff and therapists and others involved with the child and to provide support, on-going assessment and intervention for the child as an integral part of their nursery/school life. The primary provision was established as a joint initiative so there were no established working practice to negotiate. Therapy staff appreciated this model, although school staff would have welcomed more direct therapy time for individual children.

♦ *Links with mainstream schools*

Working together

One mainstream support service for children with a statement identifying speech and language therapy needs is designed to 'assess and manage these children, providing support in the form of direct intervention, programmes of work to teaching and support staff, and advice and liaison with involved professionals and parents'. Such support is available to those waiting for (or returning from) language unit or other placements. The links came about because it was recognised that speech and language therapy was, as a clinic-based service, isolated from the education children receive. The therapists' own evaluation highlighted not only the substantial mutual understanding that exists between therapists and teacher, but also the gaps in knowledge on both 'sides'. It appeared that information that

would be of interest to class teachers needed to be more accessible to them and that there was considerable scope for agreeing on aims and strategies for classroom work with children experiencing difficulties. The service sought to facilitate 'a high degree of shared knowledge, skills, expertise and information among all those involved with the child'.

Therapists visited schools termly and the onus was on school staff to maintain that momentum and, clearly, some were more able or willing to do that. As one therapist working on mainstream support explained: 'Teachers vary too. Some are very keen to talk; those with huge classes and less support find it difficult to find time.' Her non-term time work was divided between clinics and home visits. The liaison between speech and language therapists and primary school staff, according to the former, was often inconsistent and only happened, as necessary, for individual children.

After a full assessment by the two sections of the therapy service, there were discussions between the support service therapist, the teacher and the parents. As a result of this the child would either be offered direct regular therapy, indirect therapy with planned reviews, reviews without such a programme or a transfer or discharge. It is the second option that necessitated the most sustained collaboration in that a contract of therapist and teacher would be discussed and agreed. This included a timetable of visits and short-term aims which could be incorporated into children's IEPs. Whatever the recommendation, therapists would 'aim to facilitate the teacher's understanding of the child's communication difficulties and offer advice on practical ways to incorporate speech therapy activities into the demands of the National Curriculum'.

Another mainstream service 'evolved' as a way of meeting the needs of children who would not otherwise have had access to therapy. It was available to children with severe, specific speech and language disorders and offered specialist assessment, diagnosis, therapy, classroom support, training and liaison with parents. It was viewed as clinic work undertaken on school premises. The expectation was that therapists would use their discretion about when to incorporate mainstream support into their timetable. The therapists who were working in mainstream settings found making time for liaison with teachers extremely difficult and were enthusiastic about the opportunities to work with classroom assistants. In some situations therapists received the appropriate level of support they required and in others they were unable to develop effective working relations. They would like to build on the training they are able to offer to individual classroom assistants, by offering a package to groups.

On another site 36 children were supported in mainstream schools, each of whom had a statement and some of whom were working with

a classroom assistant carrying out a speech and language programme. There was some overlap here in that clinic-based therapists also worked in schools, although children were referred to the mainstream team if there were sustained concerns about their progress. Education funding for this work came about as a result of integration policies and a review of out-of-county placements. The service was instigated for children who, in other areas, would be placed in units. While acknowledging the value of these arrangements for 'a certain group of children', the therapists involved expressed their concerns about those children who could still benefit from out-of-county placements, those who would be suited to unit provision and those who do not have a statement, but need intensive treatment.

Issues in grass-roots collaboration

Teachers sometimes felt the weight of competing priorities in relation to children with speech and language difficulties. Focusing on the meetings held about one child, one teacher explained that 'this is an enormous amount of time for one child. Well over an hour..., it tends to be the people who come (e.g. therapists) who take the time. An hour is too long, I've got 32 others.' Where therapists were working with schools providing advice and educational programmes but the structure was such that they were not able to spend time in school, considerable frustration was expressed by the staff on the receiving end of this support. There were clearly difficulties in clarifying the implications of the therapists' enabling role in schools. The problems centred around the need for:

- Therapists to work in schools so that staff could see, rather than simply be told, how activities were to be done.
- Therapists to spend time with children in the classroom context.
- **Some** face-to-face contact, which was considered much more beneficial than devising an educational plan and simply posting it to the school.
- Programmes to 'fit'. Without effective liaison it was up to teachers to work out how to utilise the suggested plan. As one learning support team identified, suggestions may be wholly unsuitable if the therapist has not had contact, e.g. 'make him repeat it, write it down' when a child may not be able to write.
- Programmes to be 'user-friendly'. Members of the support team expressed concern at the number of programmes 'tucked away at the bottom of the cupboard', especially those that were 'six pages long'.
- Joint 'ownership' of the programmes in the sense of those charged with their delivery playing a part in their development. Without this there could be friction and a negation of what children had to offer.

Joint planning and discussion

♦ *The language panel*

A consistent approach to referrals and placements

One example of constructive teamwork was a recently established language panel. This included representatives of the children's speech and language therapy service, the learning support service, educational psychology and schools. They considered referrals for language support and had an overview of provision that had been absent before. Placements could now be recommended from an informed perspective taking a variety of factors into account. This move from some pockets of autonomous decision-making to a system of referral that was clearly understood and negotiable had resulted in some very productive multi-agency working. By systematically reviewing the provision in this area and creating a forum for discussion, the panel had had an impact on collaborative working. Language provision had been brought under one umbrella with agreed criteria for recommending placements, and channels of accountability.

Pooling expertise

The educational psychologist on the panel spoke of the 'common understanding of each other's backgrounds' that had emerged 'as a side issue', paving the way for further developments. There were, for example, plans to establish a multi-disciplinary group to consider the assessment of children for whom English was a second language. Without a structure to facilitate the formation of such a group, the only progress that would have been made on this issue would have been if interested individuals had approached colleagues from other disciplines. The language panel provided a springboard from which such initiatives could grow and a vehicle for the effective dissemination of suggested practices and policies across professional groups.

♦ *Funding a service*

The funding for one mainstream support scheme came about because, as the head of service explained, 'everyone recognised it needed to happen'. Education staff were concerned about their position, feeling 'totally vulnerable' in negotiations in that the purchasers were able to determine what was provided. Dealing with provision in two sectors (education and health) had seemed like a 'no-win situation'. Education staff and purchasers both agreed to contribute financially, with £40,000 coming from education and a comparable sum from health. Managerial control was vested in the therapy service. Given the concerns about the low levels of therapy support (and the possibilities of litigation), elected members were responsive. This allocation was a 'step forward' that 'set the scene for better negotiations'. At this point purchasers seemed more approachable and 'relations seemed to get more manageable'. There was some constructive collaboration and a sense of working together. Education staff would now discuss requests to providers with purchasers. There was mutual respect and communication about 'trying to get more [therapy]'. The aspiration now was for joint service level agreements and contracts with clear

criteria. As the senior education officer explained: 'You are dealing with the whole rationale for special needs resources — not just saving a few bob.'

Joint establishment and development of services

♦ *Setting up intensive speech and language groups*

These groups were designed to support school staff as they worked with children experiencing difficulties. The special educational needs adviser explained that a few years ago headteachers of special schools had been very concerned about the low level of therapy available for their pupils and were under pressure from their governing bodies to ensure an adequate supply. There had been many meetings with the RHA and, by reorganising some learning support budget money and making a case to elected members, it had been possible to fund 0.6 of a therapist for school work. More recently, anxieties about the lack of provision resurfaced and the present mainstream system was established. Education funding for this work amounts to £40,000 per annum. Funding was also provided from GEST 23 money for the initial stages, allowing some supply cover for teachers and the purchase of some equipment.

♦ *A community-based programme of parent education and support*

This was a trans-agency scheme established to develop an integrated support service through all stages of parenting, with an emphasis on the early years. The work was targeted at parents who have been reluctant to attend other services and was established in an economically deprived part of a large town. As one key worker explained: 'What we're doing is trying to raise parents' awareness of the importance of what they're doing — the language acquisition is not something that will develop out of the blue.' Parents attend morning sessions on a weekly basis, moving from 'enjoy your baby', led by the HV, through to 'walkers and talkers' facilitated by therapists. Further sessions covering the older children through playgroup and into school are planned.

Developing collaboration

The educational psychologist involved outlined what had helped to facilitate good collaboration. He explained that their mode of organisation (with each module of the programme being led by a professional who has to liaise with other agencies to set their module in context) meant that you 'almost **have** to be aware of the other people's perspectives'. There had been a lot of time set aside for discussion in the early stages. Making an effective contribution to other professionals' modules, as appropriate, was possible because the staff were willing to be flexible. The psychologist explained that: 'I'm not saying we've got that right, but that's what we're trying to do. We're trying to get genuine commonality of purpose, genuine respect for different perspectives, and look at how professional roles can complement each other.'

4. THE FIVE AREAS OF STUDY

BACKGROUND TO THE SPEECH AND LANGUAGE THERAPY SERVICES

As stated, the research was undertaken in five areas, with the speech and language therapy service being the starting point in each. Some details of each of these areas are presented in Table A. All five children's services operated an open referral policy (i.e. did not insist on referrals from doctors). Health visitors were the main source of referrals at pre-school level, with education staff taking the lead with those of school-age. There was general agreement that very few children were put forward for therapy by GPs, although this may have been because this was delegated to HVs. Most of the services reported significant recent growth in referral rates, for example one reported an increase of 35 per cent within the last five years. As Table A shows, waiting times varied across sites and three services were experiencing difficulties in staff recruitment.

The services concerned varied considerably in terms of the geographical areas they covered and included a mixture of rural, urban and inner-city areas, including inner-city development areas and a multi-ethnic district with over 100 different languages represented. Figures for the ratio of therapists to the child population should be treated with caution, given the variation in the age ranges provided (from 0-15 to 0-19). Allowing for these differences, the number of therapists per 10,000 children was between 1.7 and 4, with three services having between 2 and 3 therapists for this number of children. Further caution is necessary, given that four of the services, notably the one with the lowest ratio of therapists to the child population, employed speech and language assistants as well.

All five services were located within Community Health Trusts. In three cases, there was a fully integrated service with an overall professional service manager. In one location the Learning Disability Directorate had an independent service, and in the remaining location the three services were headed by chiefs within the three directorates concerned. Collaboration with education was made more difficult in this last case as the learning disability service provided a speech and language therapy service for children with severe learning difficulties, including those integrated within mainstream schools.

KEY FEATURES OF THE FIVE CASE STUDY SITES

The context

	A	B	C	D	E
Description of area	Large rural and small city	Urban. Overspill area from inner-city	Combined city/rural area with significant inner-city 'development' area	Rural, large town	Inner-city 100 + languages
Total population	560,000	346,000	338,000	327,000	207,000
Child population	113,000 0-16	93,000 0-19 in special schools 0-16 in community	62,800 0-19	68,000 0-15	40,000 0-15

The clients

	A	B	C	D	E
Caseload total (children)	1,589 pre-school 2,614 school age	1,924 45% pre-school 55% school age	1,870 35% pre-school 65% school age	1,137 pre-school 1,607 school age	'about 1,800' Age profile as below
Referrals 1994 (children)	1,310	1,007	1,270	1,080 pre-school 506 school age	'about 1,000' Was 65% under 5s, now shifting significantly due to Code of Practice (1994).
Referred from:	HVs 44% Education staff 40% GPs 3% Self- referral 2% Social Services 6% Other 5%	HVs 30% Education staff 24% Self referral, consultant paediatricians, other medical staff, and transfer from other Districts 46%	HVs 44% Education staff 22% Whole range of professionals and parents 34%	HVs 35% Education staff 45% GPs 3% Self-referral 3% Paediatric medical 3% Ear, nose and throat 3% Other medical practitioners 3% Other 5%	mainly HVs/ CMOs (pre-school) Enormous increase in referrals from SENCOs since Code of Practice (1994) and 1993 Education Act. 93/4 - 94/5 – 60% increase in referrals to clinics.
Increase in recent years	—	35% in last 5 years	29% in 3 years	Slight increase in the proportion of referrals from education	300% increase in number of statemented children in mainstream

The service

	A	B	C	D	E
Children's Service	17.7 therapists 6.0 assistants	15.3 therapists 2.1 assistants 3.0 clerical	13.9 therapists (including 2 management therapists) 1.2 research therapists 2.5 assistants 1.7 clerical	14.8 therapists 1.0 assistant 2.0 clerical	16.0 therapists 1.0 clerical – for whole of service
Recruitment difficulties	'Not significant'	'Not significant' – difficulties at senior levels	Difficult all levels, particularly experienced therapists and fixed term contracts	'Not significant'	'Difficult at senior levels'
Waiting times	Generally 4 months for initial appointment and then maximum delay for therapy of 2 months. (Drop-in clinics for screening also available).	No waiting times in language units and special schools. Standard for community clinics of 13 weeks for initial appointment and then normally no delay in commencing therapy.	Average wait for initial appointment of 6 months (longest is 10 months) and then generally 3-6 months delay for therapy (longest is 8 months).	Initial appointment within 4 weeks and usually no delay in commencing therapy.	12 weeks for initial appointment but may be considerably longer. Wait for therapy varies according to the nature of the child's difficulty and other agency involvement.
Prioritisation	Recently standardised	Formalised and used throughout service	Following referral, prioritised predominantly by date of referral (with some exceptions). Following assessment, prioritised according to degree of need on formal rating scale	Structured support system for therapists includes mentoring sessions where prioritisation will be discussed to ensure consistency across the service	In process of standardisation
Base	Community Trust Integrated	Community Trust. Adult learning disability service-separate directorate and management	Community Trust. Children's Service is in a separate directorate from Adult and Learning Disabilities Services. Each headed by Chief Therapist. No overall head of service	Community Trust Integrated	Community Trust Integrated

Other agencies

	A	B	C	D	E
Main purchasers	Commission	Commission	Health authority	Commission	Health Commission
GP organisation	'advanced' information system and cost per case contracts with 67 GPFHs in place	block	block + 1 separate	sophisticated blocks	block
Schools	No language units Few special schools Integration	8 language units 11 special schools 65 and 60 primaries respectively	1 language unit 3 special schools 3 special units 105 primaries	1 mainstream language provision 5 nursery language provision	2 language units 89 primaries
Number of therapy services for LEA to work with	3	2 LEAs served by 1 therapy service	4	2	Co-terminous
Cross-boundary issues	Not seen as a problem at the moment, although 'knock for knock' may cause difficulties in the future. Issues are being discussed.	GP funding becoming an issue Significant cross-boundary flow within schools – not currently a problem but is being watched	Not significant problem in schools Problems with GPFH on border. Children attending out of district schools are referred back to GP for therapy		School placement currently balances out but will become an issue
Funding from Education – SLTs	1.0 therapy post	NONE	NONE	NONE	Recently increased to 3.9 therapy posts
– Assistants	Part of classroom assistant for speech and language work via LMS	NONE	0.5 assistant under LMS	Funding for assistants – can be for purely speech and language work	NONE
– Other (indirect)	LEA approved use of classroom assistant time with statemented children	a) Education fund NNEBs to work with statemented children – not in collaboration with the therapy service b) LEA dual qualified teacher/ therapist in language units	Pay for training courses. Trained classroom assistants in some schools	LEA approved assistant time for statemented and sub-statemented children needing speech and language support	Recently 0.3 therapist's salary for preschool language unit and under-5s centre

Other agencies

	A	B	C	D	E
Manager/chief therapist meets with:	3 district therapists used to meet director (special educational needs) – now he meets purchasers. Statementing officer, administration chief for community to liaise re placements.	Steering group meets regularly. Not regular, but all children discussed with statementing officer before entry to language units.	Senior special needs administrator Senior special needs adviser Termly	Assistant education officers Statementing officer Heads of special needs assessment teams	Inspector (special educational needs) and LEA planning officers
Educational Psychology Service	Regular – as needed	As needed	Termly	Monthly – developing relationship	Regularly – close relationship
Support Teaching Service	Developing relationship	As needed	No service contact – service shrunk – liaison over individual children	Monthly – developing relationship	On management team of learning support service
Others	Head of service meets with assistant director of education (special needs) for operational and strategic development issues.	Headteachers of special schools Special needs adviser Access to executive minutes Voluntary bodies, e.g. AFASIC Manager is governor of special school.	Language Support Centre administration meeting Annually	Under 8s working party Child health directorate (Acute Trust)	Autism Working Party Head of education and learning support service Language panel

Training

	A	B	C	D	E
By speech and language therapists	Not widespread. Offered if requested INSET, teachers, assistants, support team	INSET provided for language units/ special Schools/ SENCOs.	Formalised, ongoing 2- and 3-day courses for teachers and assistants and *ad hoc* sessions on request	A variety of training – only by request	INSET compulsory for schools involved in intervention
Issues	Arising as result of others seeing need Would like to develop – all levels	Active, ongoing, high-quality (consistent) seen as part of role	—	Would like to develop training package for assistant and headteachers	Seen as integral part of service Would like to develop more
For classroom assistants	On-the-job Recognised to be inadequate by both	As needed, on-the-job and formal	On-the-job when needed and 220 have done the course	On-the-job	Regular INSET for special needs assistants
Funding	Schools would have difficulty funding supply cover	Generally 'free' Schools would have difficulty if asked to sponsor	Applications plummeted as result of cuts in education training budgets and supply cover	—	—
Other training provided	At request (little)	At request (developing) Education buy places when external speakers come for therapists	On request (e.g. GPs) Developing with HVs	At request, e.g. Parent Health promotion. HVs	Initial teacher training. Early years etc.
Training of therapists by education	*Ad hoc* invites from schools. Request *re* Code of Practice (1994)	Not offered; schools happy to include therapists if asked	Not offered. Request *re* National Curriculum training not followed through – bought in from out of area	Not offered. Informal, e.g. support team meetings	Not offered – but regularly included in training offered to education staff
Budgets for therapists' training	'good'	£1,000 for whole department	'limited'	Budgets held centrally by Trust training/personnel department. Speech and language therapy can fund independently on occasion	£33 per head per annum

5. POSITIVE PRACTICE

Collaboration is never easy to achieve. Even when staff are trained in team work, share the same profession, employing authority and manager, and work within an environment which fosters, facilitates and rewards collaborative work, there are still difficulties related to the essential features of the complex collaborative process itself. Designated time to plan, review and consult is vital and needs to be built in as appropriate. That so much constructive collaboration was identified in this study is noteworthy. It was only five years ago that Maychell and Bradley (1991) reported that 'it must be recognised that multi-agency collaboration is in its infancy. It has reached a stage in its development when the main task is to take stock and plan for the next step.'

This section draws out the main themes emerging from the research with particular regard to factors that were perceived as facilitating collaboration. It begins with two examples of grass-roots work that were universally well-received and then considers collaborative policy-making and planning and the need for well-developed information systems. Further, more general, points relating to the pressures of time, training needs and the value of guidance and structures are outlined at the end of this section.

COLLABORATIVE ACHIEVEMENTS

Speech and language groups

The work in primary schools involving groups established by therapists and support teachers was generally regarded as an effective and worthwhile enterprise. This was the clearest example of joint planning and development of a collaborative venture. Discussions between the adviser, psychologist and therapists had led to a mutually agreed scheme. Considerable funding from education had followed. It is important to note the cautious approach taken. As the therapy manager reported, they were conscious of wanting to get this mainstream work right and that was why it was being piloted in just a few schools. They knew they were 'charting new ground and that it could be really overwhelming'. The essential features of this initiative were that:

- There was broad consultation in the early stages. The educational psychology department, for example, had been able to suggest some pointers about school organisation that had been fed into the planning process.

- There was funding and a firm commitment to the approach from the education department. To them the work felt 'like making progress. It gives a positive message to parents.'
- The cautious approach, referred to already, was chosen so that the scheme would have a 'flying start' and there would be a model of effective working that other schools would wish to emulate.
- The work commenced in schools that were committed to incorporating speech and language therapy support into their work with children.
- Relatively senior therapists with well-developed inter-personal skills were involved. Such staff needed to have real confidence in their work and to be able to liaise successfully with other professionals and parents.
- Skilled therapists were required to overcome any wariness about what this collaboration could achieve realistically and any uncertainty about what therapists could contribute. It was generally agreed that the scheme had demonstrated how therapists could work with school staff to enhance children's development.
- Staff from both education and health were involved in drawing up an outline plan for the work in mainstream schools. This groundwork was a joint exercise, with all staff involved being represented.

Frustration was expressed in some of the schools taking part in this work in that, while applauding the advantages the group work brought, they were unsure whether it could continue if further funding was not made available for supply cover. There was a general concern in schools that this could seem like taking a lot of time out of class for a few pupils and the school needed to be able to provide effectively for children whose teachers left their classes. Providing cover for two mornings per week could make quite an inroad in a tight supply budget. Even the headteacher, who was convinced that the contact had been beneficial and was a very effective way of passing on expertise, was unlikely to be to able to sustain the group work next year without additional funds being made available. In schools where the SENCO had adequate non-contact time to allow for liaison and groupwork this was clearly less of a problem.

Training courses

The training courses therapists had provided were generally well received. They were seen on the whole as well-targeted and professionally delivered. As one headteacher explained, they were 'excellent, sharply focused, high quality, just what we wanted'. The courses were responsive to participants' knowledge and experience and one senior therapist involved was adamant that 'in two-and-a-half years [we] are really changing attitudes. There's no doubt about it. Not in all schools, but [we] are getting there.'

Situations where classroom assistants were trained and were then able to build-in daily sessions with the children they were responsible for were particularly commended by school staff. Group work provided the opportunity for several children (not just those targeted for support) to benefit from specialised activities. In one area, where classroom assistants were being trained as part of an approach to meeting children's needs in an area where there had been no clinic for many years, headteachers were appreciative and the therapist with overall responsibility was enthusiastic about the regular timetabled sessions many assistants were able to give that helped children 'better than clinic and home could have done'. She argued that this approach 'gets help to the children who need it most'.

Headteachers felt that this was the way forward, emphasising the value of this targeted approach, reaching children who were likely to benefit most. The courses were well-attended. Indeed, the teachers' courses had come about because of the success of those for assistants. That they would not be able to run courses this year, due to school budget restraints, was causing great concern among the therapists involved. After an initial outlay for the (subsidised) course, schools were then in a much better position to meet children's needs and to maximise the benefit staff could gain from their continuing contact with therapists. If they understood why therapists were approaching children's difficulties in a particular way, they were better able to contribute themselves.

Running through these positive comments about the benefits of the training was a concern about not having enough therapy sessions allocated to the schools if a significant amount of time was spent on training. There was also some frustration at not having follow-up after the courses. As one headteacher explained, trained assistants should be 'applying knowledge and skills, alongside the therapist'; but the danger was that, having run the course, therapists had 'too high expectations' of staff and did not provide adequate back-up support.

COLLABORATIVE POLICY-MAKING AND PLANNING

Within the services taking part in this study there was recognition on the part of the vast majority of professionals concerned that greater collaboration was needed on the part of education and health services in order to provide better for the needs of children with speech and language disorders. At an individual level a great deal of professional time and effort was being spent on establishing and maintaining collaborative working practices, yet there were few examples of close and effective inter-agency collaboration, and relatively few examples of a systematic approach to developing joint working practices. In common with the other professional groups of health and education providers, the speech and language therapy service was characterised by much good collaborative practice and was seeking to develop further structures and schemes.

Few LEA and health authority boundaries are coterminous. In many cases this means that LEAs are negotiating with more than one provider of speech and language therapy services; similarly some services are dealing with more than one LEA. NHS purchasers and providers differ in their priorities, and in their policies and procedures for the resourcing, organisation and management of the service. This means that an LEA may receive differing and possibly conflicting advice about speech and language therapy provision and there may be varying standards and practices in service provision across the district. There is also little conformity amongst LEAs in the priority they are perceived to be attaching to the provision of services. Commonly, large LEAs are divided into sectors which may themselves have slightly differing policies and procedures. Some key issues, highlighted by policy-makers and planners, are listed below:

Information

- An essential backdrop to any negotiations was a comprehensive information base and there was general agreement that this should be strengthened. As one purchaser explained: 'There are statistics for everything in the acute sector but little for community. The information base is poor and inaccurate.'
- Some concerns were expressed about education staff not having a clear planning framework and being unfamiliar with budgeting procedures, and also about purchasers being unaware of the issues in educational delivery. The solution, as one adviser explained, was for strategic planning following informed debate.
- Concerns were expressed about which units of measurement could be used to reflect accurately the work of the speech and language service. The extent to which the number of face-to-face contacts would serve as a useful measure, for example, was unclear. Providing training for education staff was generally agreed to be an effective approach to meeting children's needs

and yet this would clearly have an impact on face-to-face contact figures. Policy-makers need clear specifications of services if effective action plans for delivery are to be drawn up.

- It was considered important to clarify what the community services were and what exactly they delivered. One concrete illustration of this pertained to equipment. If staff could clarify where equipment was to be held, who was to provide what and how it could be accessed, those in need of equipment were more likely to receive appropriate help.

- Purchasers' and providers' priority was effective service delivery, rather than rigid demarcations of responsibility. As one clinical services manager explained: 'It's not a business approach really. The main priority is to provide a service, not endlessly to argue about who should pay.'

- The aim was for a 'seamless' service for clients, such that professional and territorial boundaries would not adversely affect the delivery of provision, nor indeed be obvious to recipients. The goal was for the best use of resources, irrespective of which agencies that might involve.

- There were several references to enhanced working relationships between education and health staff and to the value of drawing on each other's expertise. Some working groups established to monitor the implementation of the Code of Practice (1994) had potential for facilitating collaborative work.

- Education and health personnel were aware of their limited knowledge of each other's budgetary systems and procedures. There would appear to be scope for improving channels of communication at all levels. There were concerns about relevant papers not being made available by one or other party, either at the planning or implementation stage. One purchaser explained how a special education needs panel (chaired by education) had been established without provider input — seemingly because of a misunderstanding about the respective roles of purchasers and providers and a view of the NHS as a unified structure where the health authority could act on behalf of the Trusts.

- The discussion of joint commissioning proposals acknowledges the responsibilities health, education and social services have to deploy their resources as effectively and efficiently as possible. Given that their aim is to achieve the highest quality services for their clients, within available resource levels, such joint commissioning may be the most appropriate way to deploy resources, avoid duplication and present a unified service to consumers.

COLLABORATIVE SERVICE DELIVERY

The parents' perspective

As stated, it was possible to obtain the views of parents on some of the sites about the support their children were receiving. Although parents were targeted because their child(ren) were involved in some form of collaborative practice, not surprisingly their comments focused on the overall quality and success of the service they had received. There were numerous comments about the skill and effectiveness of the therapists parents had had contact with, irrespective of the context in which speech and language therapy was provided. It was striking that only one of the parents was critical of the quality of service her child had received, although several others were unhappy with the process they had been through and the delays they had experienced. Parents were reassured when regular contact with the therapists who worked with their children's schools was available to them. Accessibility of staff was appreciated greatly. Only one parent, whose child was being supported in a mainstream setting, spoke of having to negotiate relationships between the therapist and teacher involved.

The provision of information to parents about the initiatives their children were taking part in was said to be something that could usefully be reviewed. Parents were pleased when something 'extra' was offered to their child and in the region of half of those invited were able to attend school meetings to discuss the activities their children would be undertaking. Staff were aware, however, that it was difficult to communicate effectively about this work and parents tended to focus on general school-related skills. One suggestion was for a video to be compiled, using a school setting, to inform parents of what their children were engaged in.

Pressures of time

- Lack of time was, inevitably, an issue when primary school staff had no non-contact allocation. One therapist outlined the constraints his mainstream work operated under, pointing out that: 'Some [schools] don't allow the time and so don't get the service. You can't do this work in two minutes and the child will be seen as having learning difficulties or as being naughty.' Working directly with classroom assistants was less problematic, given that assistants did not have whole-class commitments.

- At one extreme, the teacher and therapist who are located at the same establishment may quickly build a close collaborative relationship, but where, more commonly, one at least is peripatetic, and a member of some number of other teams, it may be difficult to arrange time for liaison and a considerable length of time may be needed for a collaborative relationship to be established. As

one headteacher explained, there was close contact with the service and liaison was built into the programme, although 'as with all good intentions, it ebbs and flows a bit; sometimes it works, sometimes not'.

- All the therapists involved in this study were aware of the constraints teachers worked under. They realised that what they might feel would be effective for certain children might not be possible logistically, given the competing demands on teachers' time and skills.

- Liaison time is also needed for staff to concentrate on the task: to discuss assessment findings, jointly agree targets, plan the intervention, agree on the division of labour and on the evaluation and monitoring of the results.

Training needs

- It was clear that staff need the appropriate skills and training to work collaboratively. While acknowledging that courses of preparation for therapists need to maintain a certain breadth of coverage as they will be working in different specialities, it must also be recognised that collaboration with pre-school and school staff and other professionals, as well as parents, is a feature of many therapists' working lives. This has implications for the continuing professional development therapists need.

- Courses run by therapists for education staff that began with a consideration of normal communication were felt to be particularly helpful, in that participants could consider that in some depth and understand what communication is about before looking at what may be going wrong.

- Courses were also said to have a more subtle impact on attitudes and approach in that there was said to be a shift towards schools realising that speech and language are not just therapists' problems, but are something that school staff need to address specifically as well. This was a dramatic improvement on the situation where staff expected therapists to 'go in and take the child and help them and send them back improved'.

- The enthusiasm with which the training of classroom assistants was described highlighted the potential that exists for enhancing their role *vis-à-vis* children with speech and language problems. Therapists were keenly aware that they themselves were in too short supply to meet all the children's needs identified and welcomed liaison with assistants to pass on their expertise.

- Given that assistants were generally responsible for day-to-day home-school liaison (normally through a book), this central role made contact through them (enhanced by appropriate training) an effective solution. This meant, of course, that they had a crucial part to play in passing on information to class teachers.

- There was some concern about fragmenting the profession. Several respondents raised the issues of therapists' development and professional refreshment if working in schools (and staff having dual qualifications) became the norm.

Guidance and structures

- One general issue that applied across sites was raised by staff from a primary support team who worked with school staff and therapists. They related the difficulties staff changes and individuals' working practices had created. The *ad hoc* nature of the work was expressed by the support teacher who explained that 'there isn't a set way collaboration is tackled, so it's very much up to the individual in that team, which is fair enough, but there isn't anyone overseeing that it's happening, so if it doesn't happen there's nothing to say it should be happening. People could go in and do the work completely on their own.'

- Those seeking effective collaboration emphasised the need for team identity, a structure and strategic management to be put into place. As one support teacher summed it up: 'Managers have to set up systems, communication systems, development systems, resource management systems. As soon as you talk about time for discussion (between therapists and other professionals) you've got resource implications and that's why there has to be some overall management structure to ensure these things are possible.'

- Drawing on each other's strengths was widely acknowledged to be valuable. As one speech and language therapy manager explained, the education adviser asked for their opinion now and encouraged their input. She felt that her team had worked hard to provide him with information and suggestions for joint working and, as a result of this approach, her staff were 'very much part of the team rather than a separate service' when they worked in education.

- Concerns were expressed that an emphasis on local negotiation in relation to collaboration in the delivery of speech and language therapy inevitably resulted in procrastination. In the absence of national guidelines or advice there was no framework for debate and establishment of best practice at the local level.

- In the absence of facilitating structures and systems, the extent of collaborative work depends solely upon the motivation and goodwill of the people concerned, and is likely to remain unstable and fragmented. An adviser spoke of the complexities of establishing a jointly funded project. How do you decide the baseline, given that purchasers will need that as a starting point? An *ad hoc* system, without long-term guarantees of financial support, increased concerns about low levels of provision.

Clearly there was optimism expressed about the climate in which future collaboration would take place. Given an increased awareness of speech and language issues and the role of the speech and language therapy services amongst teachers and doctors, the onus was said to be on the service to ensure that its successful practice was recorded. There was, undoubtedly, a considerable amount of work to be done with other professional groups and a great deal of negotiation to undertake, but there was progress to record.

While a number of successful attempts at developing collaborative working practices were identified in this study, some of the potential further advantages of extending these approaches were also apparent. These included: establishing consistent local care philosophies (on priorities and modes of delivery); clarifying roles, responsibilities and objectives and minimising imbalances, gaps, overlaps and conflicts. The 'ideal', as several respondents outlined, starts from an assessment of needs and the best way to meet them, rather than from a standpoint of organisational boundaries and traditional territories.

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SPEECH AND LANGUAGE THERAPY SERVICES FOR CHILDREN

This research looked at collaboration between the education and health services in the delivery of speech and language therapy services to children. The study was undertaken in five areas across England and interviews were conducted with therapists and assistants, classroom teachers and assistants, support teachers, educational psychologists, headteachers, parents, purchasers, senior NHS Trust personnel and education advisers. The report provides an opportunity to put on record, for discussion and debate, how collaboration is being established and factors that will encourage further progress.

The study identified a continuum of six stages of collaboration from liaison through to joint commissioning of services and found evidence of the first four. What was abundantly clear was the commitment to collaborative ventures that exists and the considerable efforts being made to enhance joint enterprises. The findings should be of interest to all who wish to develop provision for children with speech and language difficulties.

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