Professional roles and responsibilities in meeting the needs of children with speech, language and communication needs: joint working between educational psychologists and speech and language therapists

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There is a large population of children with speech, language and communication needs who have additional special educational needs (SEN). Whilst professional collaboration between education and health professionals is recommended to ensure an integrated delivery of statutory services for this population of children, formal frameworks should be developed for the exchange of information during identification and assessment of needs and planning of intervention strategies. In this study an audit was carried out to examine practical and conceptual issues which might arise in a piloted communication system between educational psychologists and speech and language therapists. Whilst it was found that 62.8% of newly referred children with SEN had some history of co-existing communication and education needs, it was shown that duplication of work exists and communication is onerous. It was also shown that schools were not fully informed about children’s needs. Joint commissioning of services is required to facilitate individual practitioners in collaborating to serve the needs of these children.

Keywords: speech, language and communication needs; multi-agency working; special educational needs

Background

It is estimated that 6–9% of children have speech, language and communication needs (SLCN), and in 1% of cases those needs are severe and complex (Gascoigne, 2006). These needs include “a wide range of difficulties” such as “fluency, forming sounds and words, formulating sentences, understanding what others say, and using language socially” (Bercow Review Advisory Group, 2008, introduction). SLCN have consequences for a child’s education; 40% of children with statements of special educational needs (SEN) have SLCN (Law et al., 2001; Bottling & Resling, 2007). For 10% of children with statements, SLCN is the primary need (Law et al., 2001).

Speech, language and communication needs (SLCN)

The main difficulties for children with SLCN in their education are the acquisition of literacy skills (Law & Durkin, 2000; Lindsay & Dockrell, 2004; Lee, 2008) and social, emotional and behaviour problems (SEBD) (Lindsay & Dockrell, 2000;
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Catts, Tomblin, Zhang, & Buckwalter, 2000; Lindsay & Dockrell, 2004; Lindsay, Dockrell, & Strand, 2007; Stringer & Lozano, 2007; Lee, 2008; Tommerdahl, 2009). Co-morbidity is suggested to be a complex interaction of within-child and contextual factors over time (Benner, Nelson, & Epstein, 2002). Social adaptation difficulties are associated with increased risk of psychiatric problems in adult life (Clegg, Hollis, Mawhood, & Rutter, 2005), suggesting that under-identification of language impairment is parallel to over-diagnosis of psychiatric disorders (Stringer & Lozano, 2007).

Professional communication and collaboration

Children with SLCN are, therefore, a population for whom collaboration between educational and health professionals can impact on outcomes (Lindsay & Dockrell, 2004). Tommerdahl (2009) argues that “it is essential that teachers and other professionals working with children with SEBD are prepared for the possible presence of language difficulties in the pupils that they teach” (p. 19). Even simple strategies implemented in the classroom or at home can help a child with SLCN, while coordinated intervention packages could improve long-term prospects for children (Northern Ireland Speech and Language Therapy Task Force, 2008).

It has been recommended that the “greater part of the provision for school-aged children with speech and language needs should be embedded within the curriculum and take the child’s educational context into consideration” (Law et al., 2001, p. 135). This can be facilitated by collaboration between educational psychologists (EPs) and speech and language therapists (SLTs) (Law & Durkin, 2000). As the nature of SLCNs change over time it might, for example, be beneficial for a joint assessment to be carried out for children with literacy difficulties. In the case of behaviour difficulties “collaborative problem solving” between teachers and SLTs has been recommended (Stringer & Lozano, 2007).

At present, professionals tend to work individually with a child and then share relevant information with an allied professional (Gascoigne, 2006). In contrast to this multi-disciplinary model, the model considered best for collaborative working is trans-disciplinary working (Gascoigne, 2006). The essence of trans-disciplinary working is the concept of a team around the child made up of a range of disciplines, each maintaining their professional specialism, whilst collaborating to produce a coherent assessment and formulation of a child’s difficulties and to construct ideas for intervention informed by all relevant expertise. Existing models include Child and Adolescent Mental Health Teams and Community Mental Health Teams. The model offers the potential for a holistic view being taken of a child’s needs and for service delivery to child and family to be streamlined and integrated (Lindsay & Dockrell, 2004). However, there are difficulties inherent in a trans-disciplinary way of working, especially when the professionals involved are employed by different agencies, and these barriers are explored further in the current study.

Research on collaboration between educational psychology services (EPSs) and community speech and language therapy services (CSLTSs)

Despite the strong rationale for professional collaboration between EPs and SLTs “all too often [the disciplines of education and health] remain separate … [and] fail to share important evidence that can inform practice” (Bottling & Resling, 2007, p. 7).
Parents express concern about the lack of clarity concerning the respective roles of health and education professionals and they cite duplication or contradiction in reports from SLTs and EPs as evidence of lack of communication (Band et al., 2002; Bercow Review Advisory Group, 2008).

Farrell et al.’s (2006) audit of the extent to which multi-agency working was characteristic of EPs suggested that the community speech and language therapy services (CSLTSs) was not one of the agencies with whom EPs were involved. A study in 2007 (Palikara, Lindsay, Cullen, & Dockrell, 2007) found that over 50% of EPs reported not collaborating with SLTs or doing so only a little; only 14% reported planning joint assessments with SLTs. A review of CSLTSs found that “coherent strategies for children using a joint commissioning framework were rare” (Bercow Review Advisory Group, 2008, p. 52). Furthermore, only 30% of respondents reported that steps were being taken to integrate services and promote joint working (Bercow Review Advisory Group, 2008).

One barrier to joint working has been found to be differing conceptualisations of need. Dunsmuir, Clifford and Took (2006) argued that SLTs sought a standardised measure of ability from EPs to determine whether a child’s needs were a specific language difficulty or a general learning difficulty, using a medical, diagnostic model of need. However, EPs have been found to be uneasy with the “function, purpose and use of cognitive assessment” by SLTs (Palikara et al., 2007, p. 133). For example, doubt has been raised about the validity of using psychometric tests to identify a discrepancy between ability and language attainments in children with SLCN (Law & Durkin, 2000).

Gaps in teachers’ knowledge about meeting the needs of children with SLCN and allied SEN may limit their ability to facilitate liaison between allied professionals. The needs of older children whose difficulties have evolved are often not fully understood as SLCN are missed (Law & Durkin, 2000). In addition, it is more difficult to integrate therapeutic ideas into the curriculum as a child gets older (Lindsay & Dockrell, 2004; Lee, 2008). Even with younger children, teachers are more likely to identify expressive language difficulties, whereas it is important to be aware of difficulties with comprehension and other receptive difficulties, particularly in children whose presenting need is inappropriate behaviour (Stringer & Lozano, 2007). Another barrier to collaboration is poor mechanisms for the exchange of information (Dunsmuir et al., 2006).

**Professional context**

Under the Children Act (2004) professionals in all children’s services are required to work towards structural mechanisms for collaboration between agencies. Whilst the long-term strategic aim is for multi-agency teams of professionals, in the interim, assessment and intervention should be viewed in a collaborative way. One of the main themes of a Royal College of Speech and Language Therapists position paper (Gascoigne, 2006) is the need for integrated delivery of statutory services.

However, it is acknowledged that there are barriers to be overcome. As well as those mentioned earlier, barriers include inadequate resources, constraints of statutory responsibilities and organisational and administrative difficulties. For example, service delivery in the CSLTS has traditionally been evaluated in terms of number of contacts with clients, thus undervaluing the work that SLTs do in liaising with and training professionals in education (Bell, 2008).
Local context of current study

In Northern Ireland the Education and Library Boards (ELBs) are responsible for meeting children’s SEN whilst Health Trusts are responsible for providing speech and language therapy for children with SLCN. This complicates the objective of collaborative working. Only if a child has a statement of SEN is it a statutory requirement for both an EP and SLT involved to offer advice on the child’s needs, and then only separately and in written form. One exception is in some special schools where, as the result of an historical legacy, responsibility on the part of the ELB to provide speech and language therapy for SEN requires the employment of SLTs (DENI, 1996). Here the service-delivery model often resembles the case work of the CSLTS.

However, opportunities for the sharing of information are embodied in professional practices. Under the Code of Practice (COP) for SEN (DENI, 1996) the Special Educational Needs Coordinator (SENCo) is responsible for seeking advice from medical professionals about whether there are educational implications connected with the child’s health. Advice, for example from a SLT, should be sought before drawing up an Individual Education Plan at Stage Two of the COP. EPs are expected to carry out comprehensive assessment, “[working] in co-operation with … the various professionals outside of school who may have encountered [a] child” (ELB, 2006, p. 7). Similarly, “[SLTs] should work with reference to the appropriate multi-disciplinary needs of the child … [and] … identify the contribution of the SLT as part of the wider team working with the child” (Gascoigne, 2006, p. 15). Joint assessment of children with educational and allied health needs has been recommended (DENI, ETI, & DHSSPS, 2006).

Whilst limited data are available about the degree to which such opportunities for collaboration are being taken, it has been found that “CSLTSs in Northern Ireland have yet to be fully integrated into early years and educational provision” and “information relating to children with Special Educational Needs is fragmented and recorded across various systems in Health and Education” (Northern Ireland Speech and Language Therapy Task Force, 2008, pp. 34, 40). A review of SEN which raised concerns, for example about the danger of duplication of work across services, also identified collaborative working as something that needs to be developed (Angus, 2008).

In contrast to gaps in collaboration at a statutory level of working, there have been a number of innovative examples of multi-agency working where SLTs have worked in a school context. The success of an initial project where SLTs worked in an advisory capacity with teachers led to Health Trusts commissioning teams of health professionals, including SLTs, to work in schools. These teams continue to advise and train teachers but they also deliver therapeutic interventions in a school context, rather than in a clinic, and also work with parents.

However, these multi-agency initiatives were not designed to impact directly on the individual case-work of CSLTSs and EPSs. Outside the context of these initiatives Henderson (2007) concludes that, “although there is evidence of information sharing … there is a need for more true collaborative working to ensure the best possible outcomes for children with SLCN” (p. 12).

In the absence of strategic joint agency policy development to bring about the necessary practices, financial and organisational structures and protocols for collaboration (Law et al., 2001; Dunsmuir et al., 2006), it has been recommended that “EPs and SLTs [make] their own arrangements to develop opportunities to develop joint planning and collaborative practices” (Palikara et al., 2007, p. 85). Farrell et al. (2006)
found that specialist posts can help overcome some of the difficulties of inadequate communication between agencies.

In the local context of this study, two full day meetings between the EPS and CSLTS had already been held. The aim of the meetings, which were the initiative of middle-management professionals holding specialist posts, was to share practice. Two issues arising from this contact provided the impetus for further work to address: firstly, concern about the duplication of testing, and, secondly, a need for greater communication and collaboration. The first issue was researched and found by Henderson (2007) to be less of a problem than anticipated. Regarding the second issue, a system of formal communication was suggested and designed by the CSLTS to address the question of how a practising SLT could know if a child has educational psychology involvement. The aim of the proposed system was that EPs and SLTs would be more aware that the other is involved and would be more easily able to liaise. The proposal was for a letter to be sent to the CSLTS by the EPS informing them of each new referral. This would lead to a written response indicating if the child is known to their service and, if so, giving information about assessment already undertaken.

Such initiatives have the potential to bring about the “consistent, relatively permanent joint structures” that are needed (Palikara et al., 2007, p. 86). In this context, the objective of this study was to pilot a version of the proposed communication system in order to identify barriers and opportunities afforded by the initiative. This work was undertaken by a trainee EP on placement with the ELB concerned.

Aims and methods
The aim of the current study, investigating proposed changes to the systems of service delivery in the EPS and CSLTS by examining current practice, was to identify practical and conceptual issues arising in collaboration between the EPS and CSLTS (Palikara et al., 2007).

In this way the study was also intended to add to the information available about collaborative professional working, of which there is little (Palikara et al., 2007). The population of interest was children with both SLCN and SEN for whom some degree of communication and collaboration between SLTs and EPs might prove beneficial. To ascertain the prevalence of such a population, and therefore the likely impact the communication system might have, a sample was drawn from new referrals at Stage Three of the COP for SEN to one educational psychology team.

The inclusion criterion was that a child was newly referred at Stage Three of the COP. Exclusion criteria were re-referrals (“new”) at Stage Four of the COP and children referred to be assessed for transition or exam arrangements.

All the referred cases that met inclusion criteria during a seven month period were included to allow a realistic evaluation of the potential benefits and sources of difficulty in the proposed communication system. The total sample was 86.

A data capture form was used to record if each of the newly referred children was known to the CSLTS. No database is held either by the education authority or the health trust about children known to an allied health/education professional. It was therefore necessary to trawl directly from referral forms to get this information. For current referrals, EPs were asked to return the information. For retrospective referrals a manual file search was carried out by the author. Question 10.1 on the referral form asks “Is the child known to any other professional?”
The status of consent for sharing of information in both the education and health contexts was examined and this impacted on the sampling process (Scott, Wishart, & Bowyer, 2006). Parents of children referred to the CSLTS do not give permission to share information with other professionals until assessment. In contrast, this consent is given at the point of referral to the EPS. Negotiation with the CSLTS led to an agreement that only anonymised quantitative information would be returned to the EPS in this study. This constituted a significant modification to the proposed communication system where returns would be made for each individual referred case.

For cases not known to the CSLTS at the time of referral to the EPS, a total of 48, a third stage was carried out. The names and dates of birth of the children were given to the CSLTS and a search of their database was carried out to gather the following information – known to CSLTS at the time, known in past, referred but did not engage, never known. A data capture form for the whole sub-sample was returned to the author.

After the quantitative data had been gathered and analysed the data capture forms were shredded by both the EPS and the CSLTS.

Consent for the trainee to carry out the investigation was gained from the principal EP for the ELB and the SLT in charge of services in the Health Trust.

Results
Sixty two per cent (62.8%) of all new referrals to the EPS at Stage Three of the COP in these two services, regardless of the reason for referral, were identified as having or having had a SLCN (Table 1).

With 70.4% of the children in the sample having both SLCN and SEN, EPs are in an informed position on receiving a referral to initiate communication with a colleague in the CSLTS (Table 2).

In 29.6% of children in the sample with both SLCN and SEN, EPs are in a position to find out about a child’s involvement with CSLTS through parental consultation, leaving them in an informed position to initiate communication with the CSLTS (Table 2).

Table 1. Children identified with both SEN and SLCN.

<table>
<thead>
<tr>
<th>Known to CSLTS at time of referral to EPS</th>
<th>42</th>
<th>48.8%</th>
</tr>
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<tbody>
<tr>
<td>Past involvement of CSLTS</td>
<td>4</td>
<td>4.7%</td>
</tr>
<tr>
<td>Referred to CSLTS because of identified need but did not engage</td>
<td>8</td>
<td>9.3%</td>
</tr>
<tr>
<td>Never known to CSLTS</td>
<td>32</td>
<td>37.2%</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>100%</td>
</tr>
</tbody>
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Table 2. Ways in which EPs are informed of involvement of CSLTS and therefore a child’s SLCN.

| Known to have current SLT involvement as indicated on referral form | 38 | 70.4% |
| Current or past involvement not noted on the referral form but which would be likely to be picked up in parental consultation which is a standard part of comprehensive assessment | 8  | 14.8% |
| Referred but did not engage. Likely to come out in parent consultation with the possibility of a re-referral to CSLTS. | 8  | 14.8% |
| Total with identified SLCN at time of referral                   | 54 | 100%  |
When referred to the CSLTS parents are not explicitly asked whether their child has been referred, or is known, to the EPS. The proposed formal communication system would enable SLTs to initiate communication with colleagues in the EPS, something they are not able to do at present. However, 55.3% of new referrals with joint SLCN/SEN were for pre-school children, a population for whom a protocol for communicating identified need has already been established (Table 3).

This is a written route which does not necessarily result in a meeting between professionals, nor a joint assessment of a child. The proposed formal communication system would constitute a duplication of administrative work in 24.4% of all cases with joint SLCN/SEN as the source of the referral to the EPS in these cases is a practitioner in the health service. The mechanisms by which this duplication would arise are shown in Figure 2.

If the proposed communication system were adopted, as well as a letter being forwarded to the CSLTS for all new referrals to the EPS at Stage 3 of the COP, in 60.4% of all new referrals an extra administrative cycle would be added to the work of EPS administrative staff (forwarding and filing a return from the CSLTS).

<table>
<thead>
<tr>
<th>Source of referral for children known at the time of referral to EPS to have joint SLCN/SEN.</th>
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<tbody>
<tr>
<td>A health professional (pre-school referral)</td>
</tr>
<tr>
<td>School (school age referral)</td>
</tr>
<tr>
<td>Letter from doctor in the case of school-age child</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Figure 2. Mechanisms for the exchange of information in the proposed communication system illustrating duplication of administrative work for pre-school referrals.
Whereas schools should identify allied health needs of children at Stage Two of the COP, in a sub-sample of 20 referred cases from schools examined, 17 out of 20 schools had reported negative findings to the question about whether there were any other professionals involved with the child (Table 4).

In 33% of the “NO” cases in the total sample the child was found to have had some level of contact with the CSLTS. It can be inferred that in a third of the cases in this sub-sample the school either had not been informed of or had not known to seek out this information. This suggests that a third of children with SEN have some level of SLCN that is either not known or not understood by school staff.

**Discussion**

This audit has highlighted a number of key issues in relation to meeting the needs of children with SLCN and SEN.

The findings of this study could be used to raise awareness about the need for professional collaboration, as it was found that the population of children who might benefit is significant. With two thirds of children newly referred to the EPS identified as having some level of SLCN, there is a clear rationale for increased communication and collaboration between the CSLTS and EPS regarding the identification and assessment of needs in this population of children. Such multi-professional collaboration might facilitate early coordinated intervention and, therefore, prevent duplication of effort, avoid confusion for parents and promote ecological interventions embedded within the curriculum.

In this investigation it has *not* been found that differing conceptualisations of children’s needs are barriers to collaboration as both agencies use diagnostic classifications to determine suitable provision for children. If collaboration between the EPS and CSLTS is improved, then in the future moves should be made to progress towards a life-span model of children’s need, rather than the current diagnostic model, to ensure that children’s SLCN are met throughout their educational career, not only at the time they are receiving speech and language therapy. Consideration would therefore need to be given to the ways in which it is recorded that a child has/has had the involvement of an allied health professional in the education context. Data sets could be kept. This will also apply to other populations of children with allied health and education needs, such as those with autistic spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD). Such data should inform the joint commissioning of services.

The main barrier to this happening is the absence of mechanisms for the exchange of information between health and education services. The findings of this investigation suggest the need for commissioning of protocols and procedures for interagency working, particularly the sharing of information.
Were formal procedures already in place for the sharing of information, the communication system investigated in this study should not be necessary. Results suggest that redundant administrative work is likely in a quarter of the cases where EPs and SLTs might collaborate if the proposed system is used. This can be taken as evidence of incomplete understanding on the part of those responsible for strategic planning about how important it is to facilitate professional liaison between education and health professionals. At present, parents are the main conduit for this process to occur.

However, in the absence of strategic planning such local initiatives could bring beneficial outcomes for children with SLCN and SEN. In the short term, information sharing would enhance understanding of a child’s needs through the sharing of professional expertise and assessment information between SLTs and EPs. In the long term, such a localised initiative could generate valuable data to inform the joint commissioning of services for children in need.

Opportunities for professionals to be informed of a child’s allied health/education needs are not being fully utilised. The role of schools in facilitating interagency working could be enhanced. Consultation or training could be used to help teachers and education professionals to understand how important it is to gather information about whether a child has or has had a SLCN, even if it is an older child with a presenting SEN which might appear unrelated.

The role of parents in facilitating interagency working should also be enhanced. This might be targeted at points of transition, using, for example, a communication system already piloted in the EPS in which all parents are asked to list, on entrance to board education provision, any relevant agencies/professionals who have been involved with their child (Crozier, 2008; Dwyer & Lambe, 2007).

The study revealed significant professional sensitivity about sharing information about children and families. In commissioning and planning protocols for inter-agency communication, such sensitivities of professionals should be taken into account. For some EPs/SLTs this might constitute a significant change in practice with which they feel uneasy. Ultimately it was concerns about sharing information without prior consent, rather than a duplication of work, which prevented the development of a communication system between EPs and SLTs as a result of the current pilot study.

Limitations of the current study

The main limitation of this study was control of the sampling; the forms of some new referrals were not available to the author via the procedures used as they were in an administrative chain. Similarly, randomisation was not possible. Two reasons for these limitations include the small time-frame allocated for the research project and the fact that no database is held of children known to both EPSs and CSLTSs.

Despite these limitations, the sampling methods did yield some useful insights. For example, it was evident that on many referral forms from schools no professionals were cited as being involved. In contrast, in many of the cases of children referred from the health trust, there was very helpful information about the involvement of allied health professionals.

The communication system proposed by the CSLTS could not be piloted in full as a result of consent issues. It was not therefore possible to explore all the likely practical and conceptual issues that might arise were this amendment to service delivery to be pursued.
Implications for practitioners

The 2008 Bercow Report concluded that it is “critical” that health and education services work together to provide for the needs of children with SLCN (Bercow Review Advisory Group, 2008, p. 52). In response, successive governments have acknowledged the importance of getting professional services right for children with SLCN by producing the document Better Communication, appointing a Communication Champion (Jean Gross, EP) and planning a National Year to focus on children’s communication needs, to be held in 2011/12 (DCSF, 2008). In the absence of formal structures, procedures and protocols for trans-disciplinary working, it is incumbent upon EPs to create their own arrangements to develop joint working with SLTs. Even where information sharing cannot proceed until uni-disciplinary assessments have been completed, EPs might consider the following as moves towards overcoming structural barriers and developing collaborative practice:

- ensuring that SLTs and EPs know of each other’s involvement and become familiar with each other’s working context, including protocols for referrals;
- calling face-to-face multi-professional meetings to develop an understanding of a child’s learning needs, strengths and difficulties based on the assessments carried out by each agency professional;
- drawing up an education plan and intervention ideas together, based on collaborative problem-solving, and making decisions about provision based on the expertise of both professions;
- calling further joint professional meetings to monitor the child’s progress and evaluate the effectiveness of provision;
- in the longer term, consider a consultative approach whereby EPs and SLTs offer joint training to schools and devise interventions suitable for more than one child.

Conclusion

This article provides further evidence to support Tommerdahl’s (2009) assertion that education professionals need to be aware that children and young people may have unrecognised or previously addressed SLCN. At the same time, the findings of this audit demonstrate some of the barriers to professionals being fully informed; communication systems are proving a major barrier for collaboration in single-agency models of service delivery, responsibility for the sharing of information for children with allied health and education needs has not been fully addressed at a strategic level, leaving significant challenges for individual practitioners. Joint commissioning, planning and funding of services are needed to facilitate a more ecological approach to SEN provision for children with SLCN and integrated delivery of statutory services (Bercow Review Advisory Group, 2008).

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