

A first class team

To make a real difference, speech and language therapy has to be provided to the right people, at the right time, in the right way and in sufficient quantity. We want to offer an equitable service but large caseloads and different methods of prioritisation interfere. In their search for a team consensus on intervention for phonological delay, Rosalind Owen and colleagues shared their practice and took some tough decisions.

Read this if you

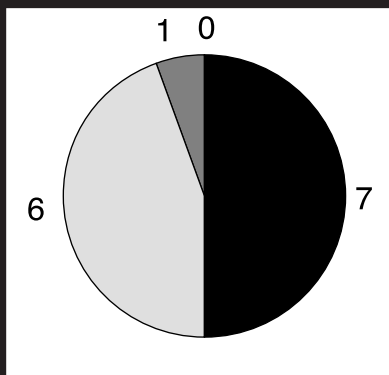
- like to take decisions as a team
- want to make the best use of therapy time
- are interested in the process of clinical judgement

As speech and language therapists, we aim to give to all our clients a level of service that is appropriate, effective and efficient. Our shared professional knowledge and expertise regarding development, assessment, diagnosis and intervention forms the basis for clinical judgements. At the heart of our work should be an objectivity that results in a first class equitable service (Department of Health, 1998).

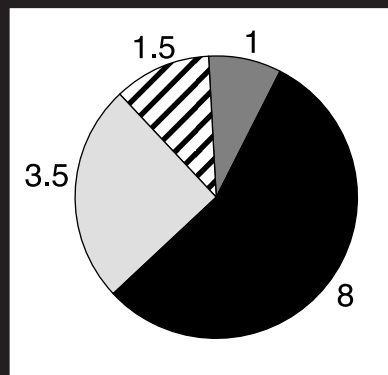
The art of our profession is to combine such objectivity with sensitivity to the needs of the individual, and flexibility to adapt to the demands of the situation. Prioritisation follows an initial assessment session and is based on information the therapist gains about the client's speech and language skills. Other factors are also relevant and taken into account, such as information about the

Figure 1 Case descriptions and management

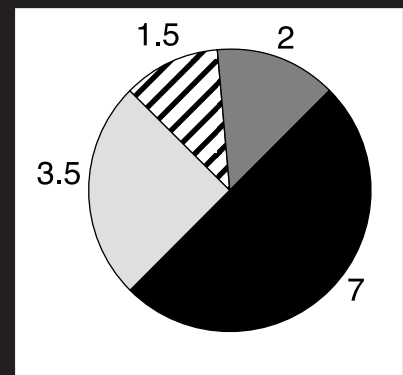
1: Male 2;6 Referred by health visitor as 'Can't understand what he is saying'. Poor language acquisition and restricted expressive language. Mostly uses single words but has the occasional 2 word phrase.



2: Male 3;3 Referred by health visitor. Supportive parents. Can imitate all sounds within system. Has established p, b, t, d, f. Does not have k, s, j, g, tʃ, dʒ.



3: Male 4;0 Referred by nursery school. Supportive parents although a little anxious. Older school age sister. Has recently started attending nursery a few times per week. Stops fricatives. Reduces clusters.



4: Female full-time. of problem Normal m Fronting v



Figure 2 Types of management strategies: definitions

Regular	2-8 (usually 6) individual/group treatment therapy sessions at weekly intervals carried out by the speech and language therapist.
Programme and review	Activities/strategies relating to specific targets provided in written form to the parent/carer or other keyworker at home/school/nursery. A review appointment planned after 2-6 months (usually 3).
Advice and or review	General advice provided to the parent/carer other keyworker at home/school/nursery. This may include a printed leaflet/handout.
Discharge	No further speech and language therapy intervention planned. The child is discharged, with the option to re-refer should further concerns arise.

Figure 3 Criteria for offering therapy

Child's speech	The child's speech skills for their age; type and severity of impairment; whether delayed or disordered; rate of progress over time; ability to imitate sounds; phonological awareness.
Support and commitment	<ul style="list-style-type: none"> From parents or other key worker to attend therapy and carry out activities or advice. Motivation of the child, in the case of older children.
General development	How the child's speech compares with other aspects of their development (cognitive, linguistic, general maturity, academic progress), and how the speech problem impacts on these areas.
Anxiety	The extent of concern and anxiety expressed by the parent/teacher regarding the problem, and any anxiety or self consciousness on the part of the child.
Intelligibility	How intelligible the child's speech is in context, and levels of frustration experienced by the child or the listener.
Caseload pressures	Numbers on the caseload; schedules for group therapy sessions.
Environmental factors	Extent of playgroup attendance; date for school entry; number of siblings.

client's other abilities, needs, background, and carers and their attitudes (RCSLT, 1996, p.272).

In community clinics, decisions regarding prioritisation following an initial assessment include:

- Does the child need therapy?
- Will it be enough to give advice and review progress in time?
- Is discharge appropriate already?

Through peer observation and discussion it appeared that, in some cases, decision making on these issues varied between therapists and between clinics. The team response to these observations was to examine whether this was really the case. If so, then perhaps we had something to learn from each other by comparing and dis-

cussing our practices and guiding principles. Through this audit process we sought to come to some agreement that would assure us of provision that was consistent, appropriate and fair.

Our aim was to examine current practice for a client group with specific difficulties, with a view to devising a pathway protocol. We decided to look at the level of consistency across therapists in the way we make decisions about initial management of children with phonological delay. We focused on this client group because of the high prevalence in community clinics, and because typical cases could be summarised more concisely than for some other types of disorder.

Six descriptions of cases as they might present at initial assessment were drawn up (figure 1). These vignettes were all imaginary, and designed to give a spread of ages and range of sound system problems. There were also a variety of external factors that needed to be considered. Each therapist in the team was interviewed by another member of the team. The case descriptions were given in random order, and two questions asked about each:

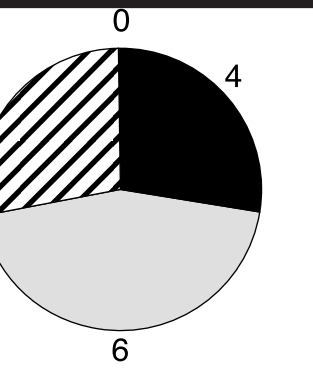
1. What would be your management of this child?
2. What would be your criteria for offering therapy to this child?

Both questions were open, without predetermined options to choose from.

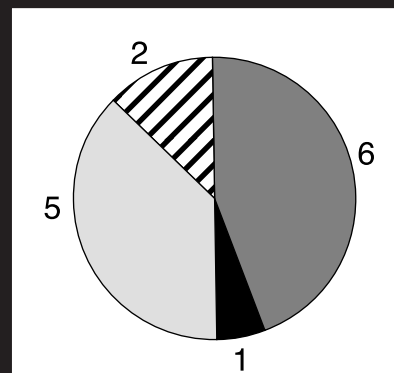
Question 1 (What would be your management of this child?) elicited a range of responses which, when analysed retrospectively, fell into four categories (figure 2).

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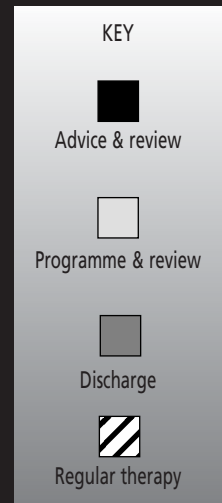
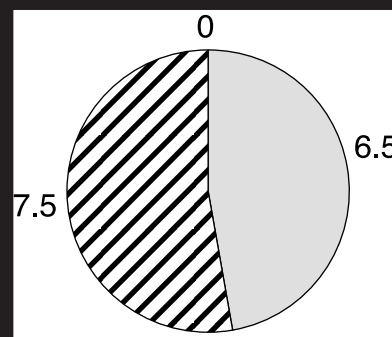
4:0 Only child with both parents working. Attends nursery full-time. Child is conscious of the problem. Parents feel it's 'not their problem'. No milestones and appropriate language skills. No velars. Stopping fricatives.

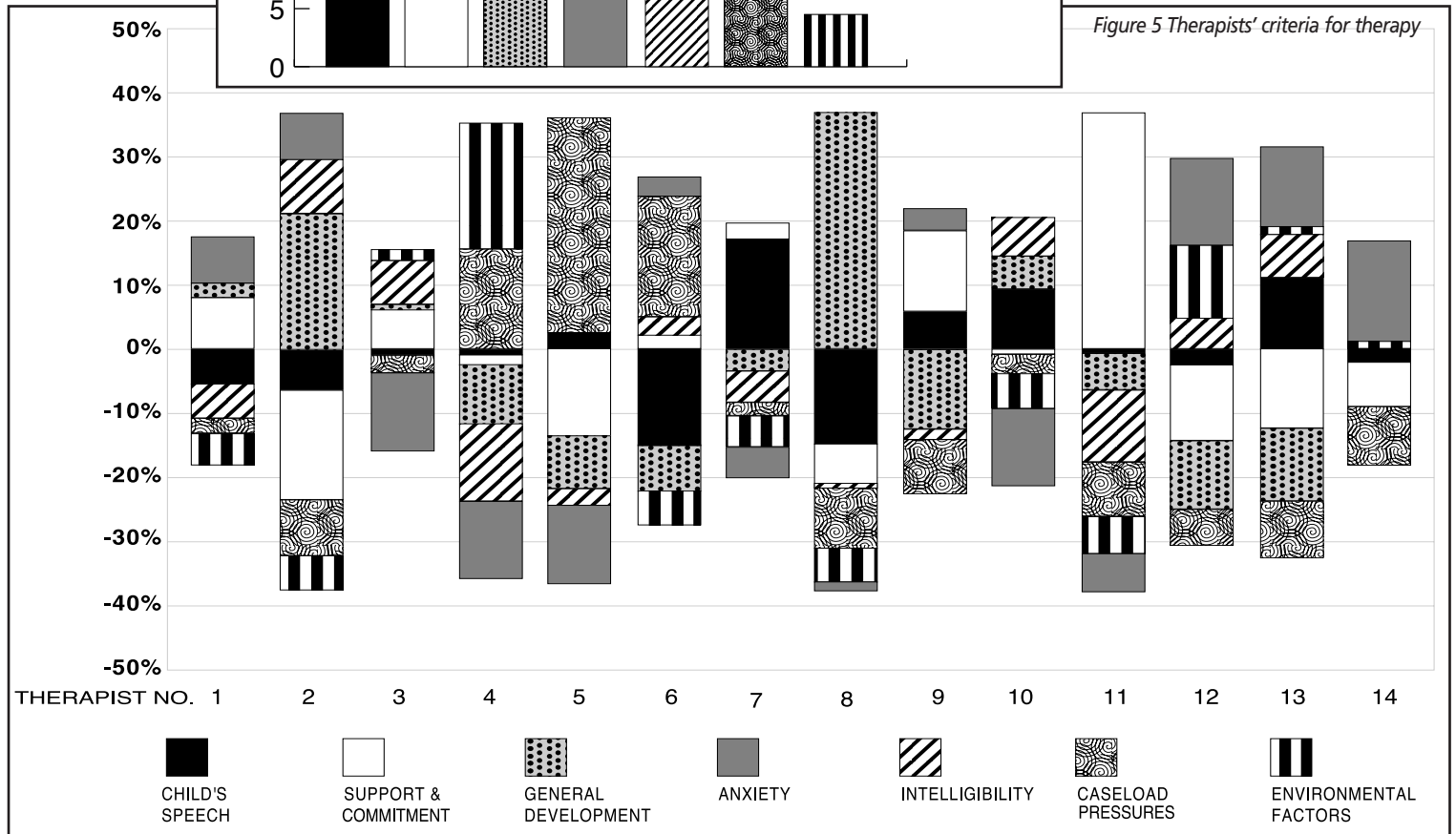
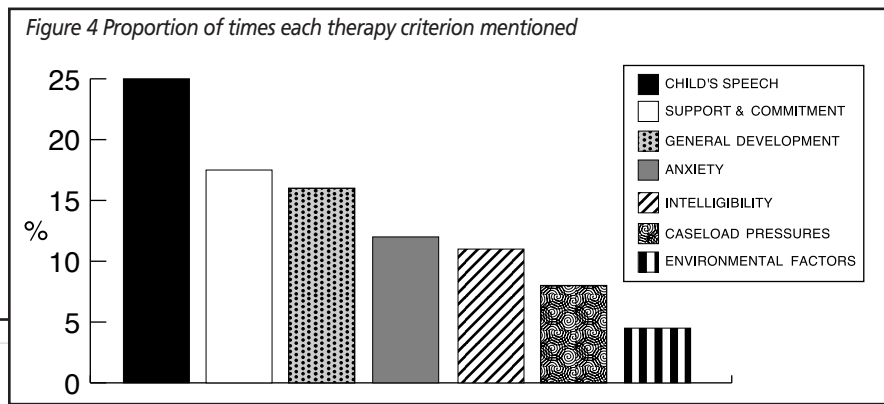


5: Male 6;0 Referred by anxious schoolteacher. Poor spelling skills and 'emergent writing doesn't show phoneme-grapheme correspondences'. Unable to say l, r, θ.



6: Male 6;0 Referred by small village school who are very concerned and would like to know how to help. Previously discharged for non-attendance aged 3 years and again at reception age. History of hearing problems now resolved. At stage 3 of Code of Practice. Moderate problem affecting social and emotional well-being and academic progress. Language skills delayed. Stopping s and f (has f). Reducing dusters.





◀ The charts in figure 1 show the type of management strategies chosen by therapists for each case. All therapists chose to review in at least some of the cases. This was a frequent choice, with a 68 per cent preference overall for review with advice/programme, showing some consistency between therapists. For three of the six cases, however, the range of responses also included the apparently opposite strategies of discharge and regular therapy, illustrating the degree of disparity which we sought to explore and address.

Question 2 (What are your criteria for offering therapy to this child?) shed light on the reasons behind the responses given to the first question. Therapists mentioned a whole range of factors that they take into account when deciding whether to give

To solve this, we selected a single chart that seemed to be the best summary of a number of studies (Grunwell, 1981), and circulated this among therapists

therapy. When analysed retrospectively, they broadly fell into seven categories which are listed and exemplified in figure 3, p.17.

We counted the frequency with which each of these factors was mentioned by therapists in the questionnaire (figure 4). Features relating to the child's speech patterns and age were mentioned most frequently, but the graph shows how a spread of other factors was also acknowledged.

The spread of factors was not acknowledged with equal weighting by all therapists. Figure 5 shows the way in which individual therapists in response to Question 2 emphasised different factors, relative to their colleagues. Therapists are randomly numbered 1-14 on the chart. While 0 per cent indicates the average for the group, bars above the line show factors that were mentioned more than average by an individual and bars below the line indicate factors that were mentioned less than average by that individual. The chart illustrates the degree of variation of all individuals from the mean.

Results promoted discussion and debate amongst the team about the role that each of these factors had to play in making clinical judgements. At the end of the discussion, we made decisions about what needed to happen to standardise and improve our practice (figure 6, p.20).

The six vignettes were imaginary and the descriptions brief. It is possible that, in real life cases, decisions and the criteria behind them would differ. Some therapists said they found it difficult to answer the questions without further information available. Other factors are also recognised as influential such as a therapist's personal level of experience, confidence, stress or areas of specialist interest. Our findings nevertheless formed a useful starting point.

From these discussions and decisions we were able to design a protocol which will be tested during the next few months. This is for use with children with phonological delay or disorder and takes the form of a flowchart (figure 7). From information gained at the initial interview, the therapist will follow the flowchart through to a decision regarding management of the case: direct or indirect intervention, or discharge. Our

Figure 7 Phonology flowchart

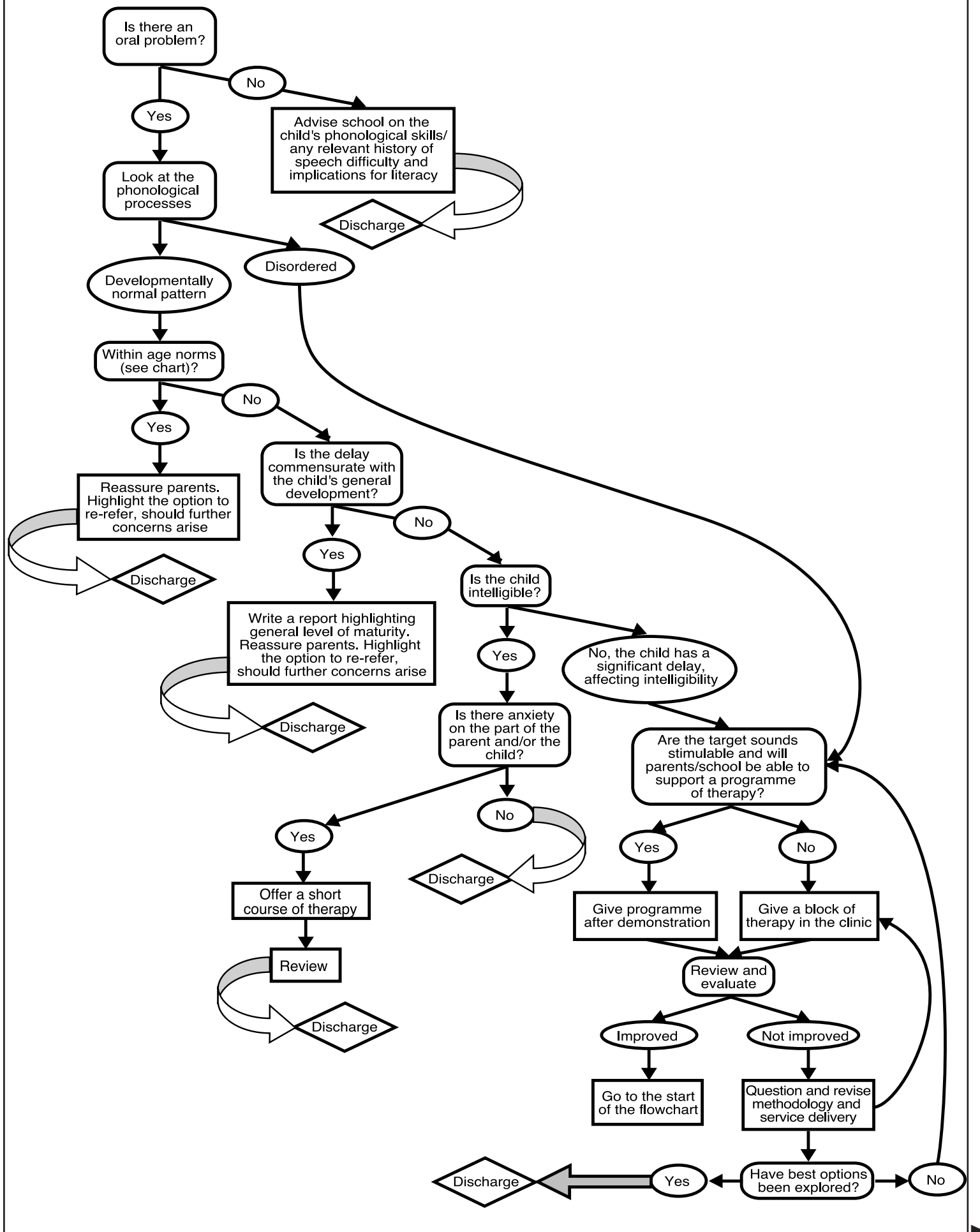


Figure 6 Discussion and decisions

Our discussion	Our decision
<p>Age norms The most significant factor in determining clinical management was, predictably, the child's speech. Therapists were looking at the phonological processes relative to the child's age. One reason for variability between us, however, was discrepancy in what was expected at a particular age. Research into published norms revealed differing findings depending on the methods of data collection and analysis.</p>	<p>To solve this, we selected a single chart that seemed to be the best summary of a number of studies (Grunwell, 1981), and circulated this among therapists as a common reference point. We also represented the same data in an accessible form as a handout resource for parents.</p>
<p>Delay/disorder All the example children in our questionnaire were showing error patterns that were delayed rather than disordered (or 'deviant'). Such a way of differentiating error patterns has been found to be of diagnostic value (Dodd, 1995). Some therapists look carefully at this distinction, and prioritise children whose speech contains non-developmental processes. In many cases, children with delayed speech can be seen to make spontaneous progress with maturity. There was some debate as to whether it is worth giving therapy as a catalyst, or whether these children can progress in time without intervention.</p>	<p>We agreed to direct our treatment towards children with disordered phonology. Our protocol would recommend discharging children whose speech is delayed. Exceptions to this were children with poor intelligibility, or cases where there was anxiety about the problem on the part of the child or parent.</p>
<p>Literacy Case 5 introduced the question of whether literacy difficulties fall within our domain. Over that case there was greatest inconsistency, perhaps because of the mention of the boy's literacy difficulties. Recent literature has highlighted links between speech and literacy difficulties (Stackhouse & Wells, 1999), and it is clear that speech and language therapists have a potential role here. The extent of speech and language therapists' involvement in literacy problems is a matter of debate (Wren, 2000).</p>	<p>In order to manage effectively the large number of children seen in clinics with oral speech difficulties, our team agreed to exclude from treatment those children whose problems were affecting written skills in the context of resolved oral difficulties. (This could change should specific money become available for such a development.)</p>
<p>Issue of support Some therapists prioritised treatment for those children who were highly motivated, or who had a supportive adult, such as a parent or school support assistant, to carry out activities and back up the work in the clinic. They argued that best use is made of therapy time in these cases where consolidation is available outside the clinic. Others felt that in the absence of this type of support, the therapist's role was perhaps even more significant in effecting any change for the child.</p>	<p>We agreed that the issue of support should be a factor not in the decision of whether the child receives therapy, but in how the therapy, if needed, is delivered. A clinic session including demonstration and provision of activities for consolidation at home or school is seen as an effective way of working in many cases. A block of direct therapy sessions remains an option, however, where indirect practice is not possible or available.</p>
<p>Parental anxiety Some therapists treated the parents', child's or teachers' anxiety as part of the problem, and included this as a reason to give therapy. Others referred only to more objective measures. Some therapists felt more confident than others in offering reassurance and reducing anxiety.</p>	<p>Indicators of a severe problem include disordered phonology, poor speech in comparison with other abilities, and poor intelligibility. If, however, there is anxiety on the part of the carer and/or the child that appears symptomatic of the speech problem, then it is appropriate to offer a short course of therapy, even in the absence of these indicators. This is seen as worthwhile, to provide reassurance and prevent any secondary communication difficulties developing.</p>

◀ new protocol takes into account all the criteria outlined in our results with the exception of caseload pressures. We excluded this because, when looking at the process of clinical judgement, we felt this issue should be a subordinate one, and dealt with separately. Staff have therefore been advised to have waiting lists.

We are in the process of piloting the new phonology care pathway in our clinics, and look

level of service, with more either being discharged or receiving therapy and fewer being kept under review. Less intervention will be provided for those children who are likely to make spontaneous progress, and more therapy time will be made available for those with significant problems such as speech disorder and poor intelligibility. We have collated all therapeutic materials in our clinic and have classified them into packages

by the demands and pressures of the situation. And, once caseload pressures are analysed and balanced, equity of service will be achievable. *Rosalind Owen, Heather de la Croix, Jennifer Lewin, Elma Lawer and Stella Davies are speech and language therapists with Wiltshire & Swindon Health Care NHS Trust, Wiltshire and N. Wiltshire and Devizes PCG.*

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Reflections

- Do we work as a team to provide some standardisation of clinical decisions?
- Do we have the best combination of responsiveness and evidence-based practice?
- Do we need initially to remove 'caseload pressures' as a variable when agreeing on priorities?

forward to sharing our findings at the Royal College of Speech & Language Therapists Conference "Sharing Communication" in April 2001. We hope it will make a difference to our management of children with speech difficulties. Firstly, children will receive a more appropriate

of care available to all therapists, so there will be equity throughout North Wilts & Devizes and West Wilts PCG. Secondly, clinical judgements will be made with more confidence and consistency. Therapists will remain sensitive to individuals' needs and attitudes without being unduly swayed