

This article appeared in the Summer 04 issue of Speech & Language Therapy in Practice magazine, pp.26-27, as part of a feature called 'How I am making a Sure Start'. Follow-up information is in: Morris, M. & Stein, L. (2005) 'Stepping stones', *Speech & Language Therapy in Practice*, Autumn, pp. 4-6.

Turning up or turning off?

Non-attendance is frustrating and wasteful. Working with a community clinic service, Sure Start therapist Tom Morris identifies why it is so common and what can be done to address it.

One of the primary difficulties facing the children's speech and language therapy service in Haringey has been the poor rate of attendance. Data collected by Sure Start from the community service found that, of children under four discharged from clinic caseloads, 62 per cent had been due to a failure to attend. A subsequent survey found that over 30 per cent of initial appointments were not attended, rising to 50 per cent in some clinics.

This had significant implications. First, the cost of the time and resources allocated and subsequent financial justification for the use of the service in this format. Second, the problems arising for children and relevant services when recurring communication difficulties begin to be picked up at a later stage, for example the increased resources required to meet the child's educational needs.

A common attitude from therapists has been both frustration and relief; the first for the time wasted on non-attendees, the second for justifying discharge from the caseload, so reducing the waiting time for others, as well as giving extra time to carry out the administrative and non-clinical duties that have become increasingly demanding.

However, one of the key principles of Sure Start is to take a client-focused approach to service development. This meant looking beyond the immediate results of non-attendance, instead focusing on some of the potential causal factors, and giving potential users of the service the opportunity to express their own ideas on any changes that could increase accessibility and reduce the likelihood of families missing appointments in the future.

Our study was largely qualitative, intended to reflect the views and experiences of parents. The interviews were broken into two sections. The first was semi-structured with open questions, such as:

"I see that that you had an appointment on _____ but you didn't attend. Why was that?"

"Where would be the best place for their initial assessment and then therapy if s/he needed it?"

"What else might make it easier for you and your child to access the service?"

These were gradually pared down, taking into account relevance, redundancy, or adaptation needed as core themes emerged.

The second included closed questions to gain relevant background information on the families.

The telephone was used for purely practical convenience, although home visits were made for those with no phone line or for families who required an interpreter (figure 1).

Figure 1 Interviews

Number Interviewed	No. Non-Attendees	No. Attendees	Interviewer 1	Interviewer 2	Telephone	Client's Home	Clinic
33	23	10	29	4	24	6	3

Samples of both attendees and non-attendees under the age of four were taken from lists of those given appointments by the community clinic team. While effort was made to choose the participants randomly, this proved difficult due to the high rate of mobility within the population. Haringey has a community of diverse linguistic, cultural, and social backgrounds. At least half, including the area covered by West Green & Chestnuts, has a population with significant socio-economic needs, such as a high rate of unemployment, temporary accommodation, and one of the largest numbers of refugees and asylum seekers in the country.

This has implications for attendance, where many residents are unaware of the range of services available. As a family in temporary accommodation has a higher likelihood of moving between referral and initial appointment than someone in permanent accommodation, this may also present the possibility of failure to receive appointments, resulting in non-attendance and subsequent discharge, although this could not be confirmed.

The low economic status of both those attending and not attending reflected high rates of unemployment, but also suggested that this may not significantly affect a family's likelihood to attend. However, there were signs of a potential influence on attendance from the family's primary home language (figure 2.).

Figure 2 Background details

	Non-Attendees	Attendees
Parent Interviewed	21 Mothers, 1 Mother & Father, 1 Stepmother	10 Mothers
Child's Gender	14 Male, 9 Female	7 Male, 3 Female
No. of children at home	Average 2.25	Average 2.25

Parents/Carers interviewed Ethnic/Cultural Group	Black A-C 6, White UK 6, Black African 4, Asian 2, Kurdish 2, Sikh 1, Irish 1, Moroccan 1	Black A-C 4, Somali 1, White UK 2, Mixed White UK/Black A-C 1, Black African 1, Irish 1
Children's Ethnic/Cultural Group (as defined by Parents)	Black African 4, White UK 4, Mixed Black/White UK 4, Black A-C 3, Mixed White UK/Irish 1, Irish 1, Asian 2, Kurdish 2, Sikh 1, British Muslim 1	Black UK 4, Somali 1, White UK 1, Mixed White UK/Black A-C 2, Mixed White UK/Irish 1, Black African 1
Primary language used at home	English 15, Arabic 1, Turkish 1, Kurdish 1, Twi 1, Lingala 1, Fanti 1, Punjabi 2	English 9, Somali 1
Interpreter needed	1 Turkish, 1 Kurdish	1 Somali
Car owners	10/23	4/10
At least one parent employed	9/23	3/10

From the initial interviews, the need for the service and its overall quality was, in general, appreciated. Ninety nine per cent could remember the actions to be taken after initial assessment, with 76 per cent happy with the advice given. Even for non-attendees, 87 per cent thought the referral had been appropriate.

We therefore decided to look more closely at the views from both sets of users on the way the service as a whole is delivered, and key themes emerged:

1. Waiting Times

Waiting times had sometimes reached up to 21 weeks and beyond for initial assessment due to the high referral rate and subsequent large caseloads. Both attendees and non-attendees identified this as being unsatisfactory. For example:

"[I was] quite annoyed it would take so long...I felt it was quite urgent so it made me uncomfortable knowing it'd be months away."

"[The service was] very good, but we were very unhappy at the wait between therapy sessions. [He] could have done with going back sooner as he definitely benefited from speech and language therapy."

One parent just expressed disillusionment with the service as a whole after having waited so long.

In a further community clinic review, an audit showed that 26 per cent of children on the caseload were being monitored rather than discharged. As this increased the number of children on the caseload, it had a direct affect on the waiting time for both assessment and therapy, which could have had a subsequent affect on

attendance. It also may have led to an increased likelihood of non-attendance at review appointments due to a lack of parental concern or a spontaneous resolution without intervention.

2. Communication

Some parents without English as a first language stated that appointment letters in their first language would have increased their likelihood to attend.

The majority of families said that a reminder by phone nearer the time of the appointment would be helpful as a prompt to attend.

3. Location

For initial appointments, the most popular location for non-attendees was the client's home, not only for convenience, but also due to factors such as other siblings, and parents' views on the importance of making clinical judgements in a more natural environment.

"[The best place would be] at home because I can't speak English and I have three other children."

"In the Health Centre he wasn't acting normally because of the environment."

"Not in a strange place, better to have home visits...more natural for a child...get a better example of what they're like."

For attendees, a clinic setting was preferred, emphasising recognition of different needs for different families.

For therapy, most parents said that both clinic and / or nursery settings were appropriate, although many stated a preference for an environment promoting interaction with peers.

"It's best to mix with people...now I think therapy would be better in nursery to get the benefit of other children."

"...when he goes to nursery there are other children who talk really well. At speech and language therapy, the other children weren't talking either. He needs to hear other children talk."

"Assessment at home to see how she interacts at home, or in a drop-in centre to see her with other children. Best place for therapy is the clinic."

Again, this stresses the need for a variety of options depending on the client's wishes.

4. Flexibility

The traditional times offered for appointments were seen by some parents, particularly those working, as being inconvenient, with either evenings or weekends preferred.

"It's not convenient for working families – outside working hours would be better."

5. Childcare

For families with siblings, the provision of childcare facilities was suggested.
“Couldn’t attend because have a younger son and no-one else to look after him. Maybe a crèche would be ideal.”

6. Awareness

Unfortunately, family awareness of the nature of the speech and language therapy service and what it could offer was poor, even though almost all the parents had identified communication difficulties in their children. This relates directly to the need to raise the service profile through both publicity and the promotion of preventative approaches with key stakeholders

Direct implications

One of the measures of the success of Sure Start’s third objective, to increase achievements of children through play and learning opportunities, is to reduce the number of children in need of referral to speech and language therapy. However, this objective cannot be met until there is a clear recognition as to what this indefinite ‘amount’ might be, given the number of potentially appropriate users who are not currently accessing the service. The interviews conducted have direct implications on the form and nature of future preschool speech and language therapy provision.

Based on the information gathered and discussion between Sure Start and the community clinic coordinator, a number of adaptations are to be implemented by the Early Years and Community team therapists supported by us. These include:

- Asking the health visiting service to identify hard to reach families who may find it difficult to attend and note this on their referral form. This will then lead to a home visit rather than an initial assessment in clinic.
- Offering more individual family work through the Sure Start community team to address other social issues that can act as barriers to attendance.
- Arranging a convenient time with the family before making an appointment for an initial assessment.
- Where possible, contacting the family by phone or text nearer to the day of the appointment to confirm attendance.
- Providing a telephone helpline for families unsure as to whether or not an appointment is necessary, or seeking advice on activities to continue while awaiting an appointment.
- Translating appointment letters into a variety of community languages.
- Working more closely on site with playgroups and nurseries, making joint decisions as to the appropriacy of referrals and subsequent actions to be taken by all parties.

This emphasises the importance of close collaboration between Sure Start and core services, and other professionals involved in both referral and follow ups. Subsequent outcomes will be closely monitored and evaluated over the

forthcoming year before any permanent changes are made to children's speech and language therapy service delivery in the community.

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Acknowledgements

With thanks to Jane Dixon, Sure Start speech and language therapist and Liz Stein, Early Years & Community speech and language therapy coordinator.