Public health approaches still have room for individualised services: response to commentaries on Evidence-based pathways to intervention for children with language disorders

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"Well, the speech-language therapist comes to talk to us occasionally, but they don't help children anymore."

Head teacher response to governing body when asked about provision for children with language deficits within a mainstream primary school.

We welcome these commentaries and an open discussion about SLT roles in improving the lives of children with language disorder. Our motivation comes in part from our lived experiences of situations like those above, where there is a perception from schools and indeed families (cf. Bercow 10 Years On) that the needs of children with language disorder are not being met. We focus our response on three key issues that arise from these thought-provoking comments.

First and foremost, we wish to draw a distinction between 'individual' and 'individualised' interventions. By advocating 'individualised' intervention we are in no way suggesting that we should return to a clinic model of withdrawing children to work in isolation with an SLT (individual intervention). We recognise the importance of working with families and other professionals with responsibility for children, and that Tier 3 interventions are unlikely to be effective without taking into account the child's local context. Individualised intervention is distinguished by its content and methods being tailored to a particular child's profile of strength and weaknesses, and its success being measured against their personal targets. Individualised intervention could be direct or indirect, may be 1:1 or in groups, and will certainly involve collaboration with other professionals and families. We are concerned that when SLTs deliver consultation or training without an individualised focus, the evidence (as it stands) is less clear that this has significant impact on a child's language or broader well-being.

Second, the commentators argue that there is a paucity of pre-service training in language and language disorder for the children's workforce and this necessitates input from SLTs. Firstly teacher training should include elements which reflect our current understanding of language development. We certainly agree that initial teacher training should also provide an evidence informed understanding of working with children with all kinds of special educational/additional support needs, including language disorder. Further, we agree that early years provision would benefit from a more highly trained, qualified and remunerated workforce. Our professional body advises on such developments and higher education institutions should continue to develop placements for both future educators and clinicians that emphasize inter-disciplinary working. Extending training and other initiatives (such as those of the Education Endowment Foundation) is needed to increase research knowledge, the ability and confidence of all professionals working with children to understand, use, and develop research evidence.

The question we raise is whether individual speech-language therapy services should 'pick up the slack' when such training is lacking. If such programmes are offered at the expense of individualised intervention, one could ask whether this is the best use of limited SLT resources. We are mindful that "a lack of evidence should never be confused with negative evidence", but we would further

argue that refocusing service priorities to areas where evidence is relatively lacking risks detrimental 'opportunity costs' not only to children and families, but also to our profession.

Finally, we welcome a public health focus on language and language disorder, but question how that approach is being interpreted by individual therapy services. The analogy with obesity raised in X's (INSERT NAME WHEN IDENTITY OF COMMENTATOR 2 IS KNOWN) commentary is revealing. Prevalence estimates are broadly similar, both arise from a complex interplay of genetic and environmental influences and both tend to be disproportionately associated with socio-economic disadvantage. If left untreated the most severe cases of obesity or language disorder increase risk for later adverse health and social outcomes.

Responsibility for tackling obesity, however, relies on many different professionals. Paediatricians and medical researchers advise the government on strategies intended to benefit the entire population (including healthy eating, exercise guidelines, and efforts to curb fat and sugar in processed foods). Despite these efforts, obesity is on the rise and so specialised clinical interventions are also required for those at the extremes, where obesity threatens health and has additional costly impacts. For these cases, GPs may refer to dieticians for individualised diet plans, psychologists to implement strategies to change behaviour, and in the most extreme cases, surgeons who provide medical interventions to radically reduce weight and prevent future costly health interventions. We do not see GPs, dieticians, psychologists, or bariatric surgeons providing generic training sessions to school staff about lunch menus or optimal PE lessons. There are programmes that education (also a universal public service) can utilise to support healthy eating and/or improved sports initiatives, but these are not delivered by specialist medical professionals nor do they replace individualised programmes for children with clinical levels of obesity.

The public health approach to obesity also tells us is that it is very difficult to change behaviour with an impact on healthy BMI. The same is true for language – if the goal is to alter a language trajectory, the evidence is that this will take sustained and relatively intensive effort. We fear that some SLT interventions in schools are not sufficiently intensive, sustained or pervasive to inculcate such changes.

The challenge for our profession is how best to deliver on-going language interventions to children with persistent language disorder when there is simply not enough resource to fund SLTs to do everything they could usefully do in an ideal world. This requires prioritisation, and our primary goal in writing the paper was to consider how services could prioritise the range of intervention options available. The local context is obviously important in making these decisions, but we strongly argue that services should be needs led, not governed solely by available resources. Prioritisation requires difficult choices, but we should be open about how we made these decisions to parents and professionals who may be disappointed that we cannot offer more. Evidence is a powerful tool in making these decisions transparent and gives some reassurance that whatever service is delivered has a reasonable chance of being effective in supporting the language development of individual children. Poor decisions stretch scarce resources such as SLT so that they are unlikely to achieve positive benefit. This wastes those resources and increases the risk to the profession that SLT will not be seen as an effective use of limited funding.

We therefore repeat our call to examine our service provision and ask 'what is the evidence that this intervention, delivered in this manner and intensity, makes a difference to children and their families?' Evidence-based practice requires us to change our approach where evidence is lacking or is negative, and to implement what has strong positive evidence to benefit all involved, especially the children.