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COMMENTARY
Cross-sector working
Speech and language therapists in education

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Abstract *Current policies and practices concerning speech and language therapy provision in schools are reviewed and issues which remain to be addressed are considered. A general move to cross-sector approaches has resulted in a move to indirect therapy through assistants, and the effectiveness of this requires to be established. Funding streams for therapy differ across the UK, and despite extensive research and policy development remain somewhat unclear and vulnerable. The implications for policies on "joined up thinking" are considered.*

Introduction

Health and education are two large and powerful public services which have different philosophies of practice, separate staff training and distinctive ways of determining effectiveness. They converge, however, in their aims of ensuring the wellbeing of children, including children with disabilities. Present government emphasis on "joined up thinking" in the public sector (DoH, 1999) means that health and education services are being strongly encouraged to work together to fulfil these aims, and to review service provision to ensure that a high level of co-operation is taking place. This paper looks at one "front line" service where such co-operation is being attempted, speech and language therapy (SLT). The issues which affect joint working are reviewed using a systems framework, with a view to illustrating some of the contrasts between health and education services, and discussing some outstanding factors which still serve to limit collaborative ventures.

Policies recommending joint working across services are driven by the sensible proposition that children's needs are best met by planned, cross-professional approaches, rather than independent initiatives. This proposition has been accepted by the SLT profession (RCSLT, 1996, p. 54), which has adopted a joint approach to work with school aged children. SLT services are increasingly being offered to children in close association with their school, and often within the classroom (Law *et al.*, 2000).

SLTs have a previous history of working within schools: until the mid-1970s there were school-based SLT services, with therapists employed by education authorities or school medical services. However, following a committee of enquiry (Quirk, 1972), SLTs have been employed by the NHS from 1974, latterly within NHS trusts. They provide services directly to clients of all ages

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and with all communication disabilities, and are in future to be commissioned via primary care trusts. Their recent re-assertion of the importance of working within education has therefore resulted in the somewhat anomalous situation whereby many SLTs are employed by health trusts but spend their entire working life in schools. This provides a powerful example around which to frame discussion of the realities of health-education collaboration.

It is also an example where much research and policy development has taken place. A Scottish Executive funded study (Reid *et al.*, 1996) looked at SLTs in schools in Scotland, and a joint Department of Health/Department for Education and Employment (now Department for Education and Skills) working group (DoH/DfEE, 2000) was set up as a result of the English and Welsh education green paper (DfEE, 1997) to advise on the principles of SLT service planning and delivery to schools in England and Wales. This group was supported by a research study into existing SLT provision in schools (Law *et al.*, 2000).

Such extensive policy-development work was needed because the differences between education and health services make joint working complicated. To illustrate the complexity involved, a systems approach adapted from the work of Banathy (McCartney *et al.*, 1998) has been adopted (McCartney, 1999a) to look at the various levels at which health services and schools collaborate.

The systems framework used considers services in terms of:

- *functions*, which include the aims and purposes of services;
- *structures*, which detail the formalised ways in which services interact, dealing with relatively permanent and consistent aspects of a service;
- *processes*, which look at dynamic aspects of service behaviour, such as the ways in which children can access services, how their progress is reviewed and how transfer to other services is organised; and
- *systems environment*, the context of communities and of the larger society in which a service is sited.

These levels interact, and insights gained in connection with one heading can he helpful in developing understanding of others and in building up a holistic picture. It has previously been argued (McCartney, 1999b) that SLT/education collaboration may work best at the process level, when staff are brought together to consider individual children. Systems environment aspects are of interest, in particular how families view services and their varied experiences of service delivery. However, important aspects of managerial interest can be considered under the headings of functions and structures, and this paper will concentrate on these areas.

Functional issues

Government policies on collaboration

Until recently, there were considerable problems at a functional level for services aiming to work together due to an overall lack of commitment to inter-

agency collaboration. Indeed Davie (1993, p. 140) reviewed the situation from a standpoint in special education and commented that, despite wide professional recognition of the value of joint approaches:

> . . . the prevailing system is heavily loaded against multi-professional co-operation. If one were to attempt – with all the insights derived from research and common experience – to establish a process designed to keep the professionals apart, it would be difficult to conceive of any improvement on what we currently have.

It is this lack of joint purpose that the government-led duty of partnership aims to tackle (DoH, 1999). A duty to collaborate, as opposed to a general exhortation to do so, has meant that services' co-operative practices are now monitored, reviewed and "held to account". The education sector has joined the health sector in welcoming moves to closer partnership, especially for children with disabilities, and has developed relevant policies. For example in Scotland it is now expected that to satisfy schools inspectors a local education authority will have:

> . . . identified the range of services provided by them, by relevant voluntary agencies, and by the health services in the area; a co-ordinated inter-agency approach is adopted where there is common involvement with client groups (SOEID, 1998, p. 34).

The joint health/education working party into SLT in schools (DoH/DfEE, 2000, p. 4) makes similar recommendations:

> . . . emphasis should be placed on effective joint working between education and health. Existing joint planning structures should be developed and priorities agreed, publicised and regularly reviewed. There should be clear statements as to responsibility for service delivery.

Such statements of overall policy have been helpful in establishing co-operative practice as an important goal to be attained by services, endorsing and encouraging SLTs' move into classrooms, and have influenced the practices of individual services.

Despite joint working becoming a service goal, however, functional difficulties remain, and three will be discussed. These are models of inter-professional working; models of how children's needs are conceptualised, and possibly the most important issue of selecting children for service.

Models of inter-professional working

Joint working can take many forms, and a variety of relevant models of inter-professional working can be found in the literature (for example Conoley and Conoley, 1982; de Lamerans-Pratt and Golden, 1994; DiMeo *et al.*, 1998; McGrath and Davis, 1992; Marvin, 1990; Mackey and McQueen, 1998). These trace the closeness of a working relationship according to the ways in which targets and objectives are set (independently or jointly) and how equal is the relationship amongst professionals. A fully collaborative approach would involve joint target setting and an egalitarian partnership between the SLT and the teacher. An alternative model where one professional acted as the "expert" and the other as the "aide" who carried out tasks prepared by the "expert", would be less likely to synthesise the skills and knowledge of both professions

in a productive manner (Cunningham and Davies, 1985). Services therefore generally aspire to develop a high degree of collaborative practice, to maximise the expertise available to the child and to prevent professional jealousies.

Unsurprisingly, more strongly collaborative approaches are found where professions experience continuity and time to plan together. For this reason it has been easier to find good examples of therapist/teacher collaboration within special educational settings than in mainstream schools (Reid *et al.*, 1996; Wright and Graham, 1997), as a fairly direct consequence of the increased time professionals can spend together. There is, however, a general expectation that most children with disabilities will have their needs met in mainstream schools (DfEE, 1997), as part of the social inclusion agenda. Delivering services in mainstream settings is proving a challenge to SLT services, which are meeting both practical problems in arranging joint planning time due to the numbers of teachers and schools involved, and in building collaborative teams with teachers who have no specific expertise in speech or language problems. This is not an argument against children's inclusion, but a practical point about resources. It is proving very difficult to run thoroughgoing collaborative approaches to children's language and educational needs when both SLT and teaching services are too thinly stretched.

Many SLT services and teachers are therefore overcoming their limited access to each other by an almost wholesale transfer of service delivery to SLTs working indirectly through assistants; either SLT assistants funded through the health service, or classroom and special needs assistants funded through education (DoH/DfEE, 2000). SLTs here must adopt a "consultant" or "expert" model with these non-professional assistants, transferring just enough knowledge to allow them to deliver therapy tasks. This role can be somewhat demoralising to SLTs and teachers who would prefer to develop more personal collaboration, but who are responding to severe limits of time and resources. SLTs' move into classrooms may involve less collaborative inter-professional working than might have been anticipated, and less than is implied in national policies.

Models of how children's needs are conceptualised

There are important differences between health and education in how they conceptualise children's needs for service. Health services, and hence SLTs, operate broadly on a "medical" model, which locates disabilities within the child and tries to alleviate them; this contrasts with the educational model which aims to adapt the learning environment to meet a child's needs (McCartney, 1999b). Health employees such as SLTs working in schools may find this difference creates considerable barriers to joint working: teachers can resist SLTs' approaches if they do not fit into the classroom ethos. Norwich (1996) argues that such tensions may be more apparent than real, as both models are important in meeting children's needs. Indeed, sharing different perspectives can be creative, and a strength of joint working is to integrate ideas and information from a variety of professionals for a child's benefit.

Diverse approaches can contribute to a holistic account of a child's wellbeing, and it is probably more productive for staff to know about and understand other professionals' conceptualisations than to engage in a battle to establish a "correct" model. Nonetheless, some explanation and discussion of how a child's needs are conceptualised will need to be shared to foster mutual understanding.

Selecting children for service

A very large difference between health and education involves selecting children to receive service. Health services require therapists to identify "cases" and to prioritise children in relation to the resources available. Educational services must, on the other hand, provide for the needs of all children, and do not take resource limits into account in determining whether to meet a child's special educational needs (McCartney and van der Gaag, 1996). These aims are very different, and can lead to difficulties in collaboration when professionals make different decisions on which children require help (Dockrell and Lindsay, 2000), or where schools resent the SLT's attempts to operate any kind of prioritisation system.

Increasing pressure of referrals is, however, increasing demands on therapy services and, in adopting prioritisation policies to cope, SLT services accept that children who are not in priority categories will only receive therapy if additional resources become available. This is an honourable position, making it clear how public money is to be spent, and attempting to ensure that the most needy children receive help. But in reviewing how prioritisation frameworks may be developed for mainstream pupils, the difficulty of establishing appropriate criteria becomes apparent (McCartney, 2000). Clinical prioritisation parameters such as a child's age, severity and chronicity of impairment, suitability of current environment and need for SLT specific expertise, are difficult to justify on educational or therapeutic grounds, and may tend to become exclusion criteria used to deal with resource and staffing limits. There is a need to agree across sectors on priorities and which "cases" require SLT intervention. However, given the problems in selecting appropriate prioritisation parameters, this will not be an easy task. Detailed efficacy research on which children can benefit from SLT services is required.

Structural issues

One of the main difficulties in working across the health-education boundary has been the lack of appropriate planning structures. This has meant that small specialist services such as SLTs have had to build *ad-hoc* planning structures to organise and deliver therapy. The current state of these structures was tracked in England and Wales by Law *et al.* (2000), who found a variety of joint planning meetings taking place between SLT and local education authority (LEA) managers at a variety of levels, and that both groups rated these as effective overall. There was some mutual doubt about the contribution such meetings made to the "other" service's development plans, and differences of

opinion between health and education managers about whether joint strategies on educational inclusion were being developed, suggesting further structural development is needed. Nonetheless, it is encouraging that a large proportion of services are now sharing planning meetings and creating structures which should benefit service development.

Some structural issues remain, however, and two outstanding problem areas will be discussed. They are the need for national structures to plan the supply of therapists, and structures to fund therapy services in schools.

Structures to plan the supply of therapists

The work SLTs carry out in schools will depend upon the numbers of therapists available and their caseload. A consensus figure of around 40 children as a caseload for an SLT working in schools was suggested by Law *et al*. (2000), but many SLTs are handling much larger numbers. There is also an overall acceptance that the pool of SLTs available for work across the UK is too small (Law *et al*., 2000). Whereas powerful structures exist to ensure teacher supply, and there has been a review of the numbers of doctors and nursing staff required to meet health service needs, structures to secure a sufficient supply of therapists have been less well developed. Recent moves to reinstate therapy workforce planning, via a Department of Health human resources workforce planning review, are therefore welcome. To secure an adequate supply of staff this review should take education needs into account, and also co-ordinate the number of SLT initial training places with anticipated needs for services to education. DoH/DfEE (2000) takes the latter point on board, and makes the specific recommendation that education interests should be represented on the NHS confederations which fund SLT training places at universities in England and Wales. At present there need be no such input from education into numbers of SLTs in training , and the working group feared that inequalities in provision and the needs of pupils might not be addressed. This would seem to be a sensible suggestion in planning an appropriate workforce.

Confederations operate on a regional basis, which will limit their knowledge base and so their effectiveness in staff planning, and their role may also be affected by an imminent reduction of health service regions in the UK. The Royal College of Speech and Language Therapists does, however, collate national figures on students in training and on graduates. Tracking the available pool of SLTs and matching them to demand should be possible. However, the gap between current SLT numbers and the required workforce appears worryingly large – there is an estimated shortfall of perhaps 2000 SLTs to serve schools in England and Wales (RCSLT, 2001). Although there has been a recent increase in SLTs in training, making up this number will be difficult: there are currently fewer than 4,500 full time equivalent SLTs working in the NHS in the UK, carrying out services to clients of all ages and with all types of disability.

Structures to fund therapists

The numbers of SLTs to be found in schools will also relate to how they are funded. Funding structures differ across the UK. In Scotland moneys – currently around £6.5 million – are available for education authorities to purchase SLT services from trusts for children with records of need (the Scottish equivalent of a statement of special educational needs). This does not solve all problems – the money is not available for children without records and so has effectively prioritised recorded children, and spending is subject to local variation and interpretation across education authorities (Working Party of SLT Managers Across Scotland, 1999). It has, however, increased the numbers of SLTs working in schools and ensured that children whose records state they need SLT input have access to the service.

Such centralised, education-based funds do not apply in other parts of the UK. The education green paper of 1997 for England and Wales recognised the difficulties posed by lack of clarity over funding. The joint DoH/DfEE working group was therefore to advise on:

> . . . new powers, to be introduced, to enable more flexible funding arrangements between the NHS and local authorities (DoH/DfEE, 2000, p. 18).

The back-up research undertaken by Law *et al.* (2000) found that funding for SLTs in schools was indeed a key issue for LEA and SLT managers. They recommended transparent resource allocation, with central government determining appropriate standards of service, and local services determining precise staff deployment according to local need. They suggested that this required a new funding stream running from central government and DfEE to LEAs, hypothecated for services to children with speech, language and communication needs, but co-ordinated by both DfEE and DoH. This resembled the Scottish model in being centrally funded, but did not relate only to children with statements of need. At local level LEAs would act as lead commissioners of services, commissioning from local SLT providers. The structure at local level was to be an inter-agency board, including parents, which would develop local service level agreements. Such an inter-agency approach would fit clearly into the "new flexibilities" encouraged by the 1999 Health Act (DoH, 1999), as an innovative example of joined up thinking.

The Law *et al.* (2000) research informed the recommendations of the joint DoH/DfEE working group (DoH/DfEE, 2000), which repeated the call for government funding. The working group also noted that in 2000-2001 DfEE "Standards Funds" money had been used to fund about 26 projects involving SLT provision in schools, selected from amongst the 121 LEAs who applied for funding. These projects received on average some £100,000 per LEA, half from the DfEE and half from the LEA. The working group suggested that this was also a productive approach, and recommended that all LEAs should be able to access Standards Funds money, as a short-term measure to enable LEAs to create enhanced SLT services.

The DfEE chose to adopt this solution as the only additional funding route. It added improving speech and language therapy provision for children to the priority areas on which Standards Funds money could be spent, and made an internal estimate that some £10 million of the £82 million allocated to special educational needs might be used to enhance services to pupils with language and communication difficulties. Although the DfEE has stated that it expects LEAs to use Standards Funds for such purposes it cannot force that to happen (Roux, 2001). This leaves SLT provision in competition with other LEA special needs priorities, and indeed with other ways of improving services to children with language and communication needs. There is continued confusion about funding structures, tracked in the SLT professional press. Some health authorities are assuming that the use of Standards Funds money means that SLT services to schools are the responsibility of the LEA, whilst LEAs argue that they cannot take on the role of lead commissioner, as envisaged by the joint working party, without a clear funding stream (Spence, 2001). Certainly the clarity, and indeed amount, of funding experienced in Scotland has not been extended across the UK, and the rather precarious nature of SLT funding continues, with many SLTs working on short-term contracts. Despite the excellent national policy development undertaken by the working group, and some innovative local examples using pooled funding (Ritchie, 2001), there remains a need for a more robust solution to the funding problem.

Conclusions

The issues raised by SLTs have resonances for policies of "joined up thinking" in general. SLTs' move towards collaborative work with schools was not originally precipitated by government policy, but by the profession's belief that children's language and communication would be advanced by joint approaches. The development of policy statements on joint working as a function of service provision did, however, help to support the move, and local structures to enhance cross-sector working have developed. However, pressure of referrals and difficulty in establishing useful prioritisation procedures have meant that the model of service offered has not been entirely collaborative, but has entailed a wholesale and largely unadvertised change in practice from SLTs offering direct treatment to children to working indirectly through assistants. This change of role was not anticipated by policy statements, and is a rather paradoxical result of the attempt to develop joint working practice.

The effectiveness of such indirect approaches has not as yet been measured, and DoH/DfEE (2000) notes the need to decide which children require one-to-one contact with an SLT and which can be dealt with using an indirect approach. Principles for deciding this are difficult to establish, however, and whether indirect/consultative approaches are an effective means of delivering services to children remains at present an open question. The National Co-ordinating Centre for Health Technology Assessment has accepted that this needs to be investigated and is funding research into this question, to start in April 2002 (Boyle *et al.*, 2001). This will compare direct and indirect, group and

individual therapy for children in mainstream schools, and should answer key questions about the relative costs and benefits of these service delivery models. Such research will be critical in aiding managerial decision making, as models of inter-professional working ought to result from managerial decisions based on evidence of clinical effectiveness, not simply on ways of coping with service pressures.

The other outstanding issue that has not been completely addressed is funding, despite clarity of funding for SLT services in schools being an aim of the 1997 education green paper, with research being commissioned and a report from a cross-sector policy-making group. Funds remain *ad-hoc*, more especially in England and Wales, and vulnerable to removal as new priorities and initiatives come on stream. This limits the attractiveness of work in schools to SLTs building a career, and creates uncertainly amongst SLT management about future trends and demands. This is a rather disappointing outcome, and leaves a pressing need for joint strategic planning between health and education managers at a local level. The shortfall of SLT staff supply is more difficult to manage at a local level, but again trust managers need to be aware of the overall situation and argue, where possible, for realistic training levels and staff planning. When so many factors are now in place for inter-service collaboration to continue and to flourish, funding and staffing problems constitute rather a large exception!

The case of SLTs shows that where a serious attempt to work across public sectors is made a number of complex issues arise. No further national initiatives seem likely, and considerable managerial time needs to be spent in negotiating local solutions and realising policy aims. As SLT services move into primary care trusts and funds for special needs devolve to individual schools, SLT managers will need to become increasingly knowledgeable about the realities of the "other" sector, its priorities and its funding complications. SLTs may be further ahead than many other NHS professions in crossing sector boundaries, but most attempts to carry out co-joint planning and working will be similarly intricate. Managers will need to prepare their staff for locally "contrived" collaboration (cf. Hargreaves, 1998), and to develop the necessary understandings which allow professionals asked to work outside of their "home" culture to practice successfully.

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