Dlígid édteanga aimsir:

Time to speak

A review of

Speech & Language Therapy Services

I.A.S.L.T.

Irish Association of Speech and Language Therapists

Bealtaine 1993

FOREWORD

IRISH ASSOCIATION OF SPEECH & LANGUAGE THERAPISTS

Message from the Minister for Health

Everyone has a right to the opportunity to develop to his/her full potential. However, integration and participation in society can be affected by one's ability to communicate effectively. Most of us learn to communicate without difficulty. A speech impediment can create barriers to communication and hinder participation in society. However, it need not be an unsurmountable barrier but is one which with professional support and quiet determination can be ameliorated and, in many cases, overcome.

I welcome the initiative of the Irish Association for Speech & Language Therapists in undertaking a review of speech and language therapy services in Ireland. There is a need for improvements in speech and language therapy provision in many parts of the country. This document will be of assistance to me in preparing a programme for the improvement of speech and language therapy services as part of my overall plan for the development of our community care services and health services generally.

Brendan Howlin

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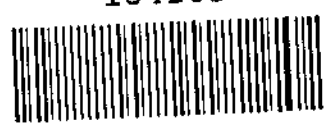

Printed in Ireland by Paceprint Ltd., Dublin

INTRODUCTION

Dligid édteanga aimsir, the Irish legal principle of 7th-8th C ensuring the rights of those with communication problems, can be translated as *'tonguelessness is entitled to time'* (Kelly, 1992). This principle included acknowledgement of the entitlements to representation, advocacy and support in law and in the organisation of social systems of people with communication disorders. The Irish Association of Speech and Language Therapists, representing the profession of Speech and Language Therapy in Ireland, offers this document as a description of the inheritance of *dligid édteanga aimsir.*

The preparation of this document was initiated and co-ordinated by the Review Working Party of IASLT, which was formed in early 1991. It is based on the result of a survey of speech and language therapists in Ireland undertaken in early 1992, regional and national workshops held in September to November 1992 and submissions from sub-groups of IASLT during 1992. IASLT particularly wishes to acknowledge the support of the then Minister for Health, Dr. O'Connell who gave permission for therapists employed in health services to attend the national workshop in November 1992.

In an effort to communicate the scope of its work the profession changed its name in 1992 to *Speech and Language Therapy.* This document is intended to reflect the views and concerns of members of the profession since the previous published reviews of services — *'Speech Therapists in the Service of the Community'* (1979) and *'Communication Needs'* (1989) examining speech therapy services for people with a mental handicap — were prepared.
The aims of the review document are:

to provide information to service planners, employers of speech and language therapists and consumers of speech and language therapy services;

to increase awareness of the needs of people with communication disorders;

to highlight the issues which influence the provision of speech and language therapy services;

to make proposals for action to the profession itself, to planners, employers, consumers and to other stakeholders.

This document focuses attention on the impact of an inadequate service on the lives of those with communication disorders, their families and communities. The IASLT hopes that this awareness will lead to a realistic plan to address those needs through appropriate improvements in speech and language therapy services. The significant time and effort invested in the preparation of this document reflects the concern and frustration of a profession which is prevented from delivering adequate services in an appropriate way.

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The Irish Association of Speech and Language Therapists believes that this document can begin a process which can reflect the concern of the Irish people, once expressed in law as *dligid édteanga aimsir,* indicating the worthiness of those with communication disorders, and supported and maintained by the whole community for the benefit of the community.

REVIEW WORKING PARTY : CLOTHRA NI CHOLMAIN
MARY FANNING
MARGARET M LEAHY
MARY RAFFERTY

Bealtaine 1993

ACKNOWLEDGEMENTS
The Review Working Party wishes to acknowledge the work of the Council of IASLT; the co-ordinators of and participants in regional and national workshops; IMPACT for its support of the IASLT survey; Mary Gregg for help in the design of the IASLT questionnaire; Geraldine Loftus in the Computer Laboratory, TCD; the School of Clinical Speech and Language Studies, Trinity College, Dublin for use of the SPSS computer programme and other facilities and Noreen Coyle and Carole Agar who helped enormously in the final preparation of the document.

The Irish Association of Speech and Language Therapists particularly wishes to acknowledge the financial support of the Department of Health, the interest and advice of its officers, especially Mr Brian Mullen, and the contribution of the Minister for Health in writing the foreword.

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CHAPTER ONE

SPEECH AND LANGUAGE THERAPY: A HISTORICAL REVIEW

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1 SPEECH AND LANGUAGE THERAPY IN IRELAND: A HISTORICAL REVIEW

This chapter looks at the roots of speech and language therapy, and how it has developed in Ireland. The professional domain of Speech and Language Therapy concerns communication and its disorders. These areas are outlined and the education of speech and language therapists in Ireland described.

1.1 Historical notes

Speech and language disorders have existed since humans developed oral linguistic systems to communicate. In the old Irish Law texts of the 7th-8th centuries there are specific references to the legal aspects of people with speech and language disorders. The legal principle which states 'dligid édteanga aimsir' (literally: 'tonguelessness is entitled to time') indicates that arrangements to protect the rights of people with disorders were in place in the courts of law (Kelly, 1992). Further, it was considered a serious offence to mock any physical disability, entitling the victim to an 'honour-price', a sum varying according to his/her rank in society.

During the nineteenth century in Europe, elocutionists moved beyond their traditional bounds focusing attention on those whose speech was "defective rather than unpolished", initiating the movement that was to develop later into the profession known today for the practice of speech and language therapy.

As one of the 1851 Irish Census Commissioners, the oto-laryngologist Sir William Wilde was partly responsible for collecting the first statistical information on deaf-mutism in the British Isles. He also reputedly had theorised about stuttering, finding it rare among the sonorous speakers of Mayo and Galway and in Dublin also, but more prevalent in the Northern parts of Ireland. Henry McCormac, the Belfast physician, also wrote about stuttering but went on to distinguish himself in the science of preventive medicine in the care of the insane (Rockey, 1980).

In 1861, Broca described that area of the motor cortex that was responsible for speech production and shortly afterwards in 1874, Wernicke indicated the area responsible for comprehension of speech. These two areas and the surrounding area in the temporo-parietal and posterior-inferior area of the frontal lobe have been shown subsequently to have critical importance for speech and language. These major advances in the understanding of speech and language functioning may well have supported the evolving elocutionist special interest in speech and language disorders.

However, it was not until this century that a profession specialising in working in the area of speech and language disorder developed world-wide although special facilities for children with stuttering had been established in some schools in the U.K. and on mainland Europe and in the USA.

One of the results of the devastation following the two world wars was a massive increase in acquired speech and language disorders caused by brain injury. This in turn led to the need for increasing numbers of therapists working with adults and an increasing awareness of the possibilities of recovery.

In Ireland, speech correction was the domain of teachers, priests (e.g. Fr. O'Flynn) and elocutionists until the 1950s when the first professionally qualified therapists were employed. Initially, they were employed to work with people with a mental handicap but soon their expertise was recognised as important for others.

1.2 Employment patterns

By the end of the 1950's there were two professionally qualified speech therapists working in the Dublin area. By 1971, the number of therapists employed in the country had increased to 19 and by 1979, this number had risen to 70 therapists working on a full-time or equivalent basis in a range of settings.

Table 1 indicates general employment patterns of therapists in 1979 as compared with those figures available from the Department of Health in December 1991.

Table 1: ***Therapists employed in 1979 and in 1991***

Employer	1979	1991
Health Boards	40	134
Voluntary Hospitals/Organisations	30	53

Cutbacks in public spending on health services during the 1980's affected the recruitment of therapists and helps to account for the slower than expected development of the profession when compared to other similar professions. The implementation of grading structures for the profession was delayed because of the lack of recruitment and loss of posts at this time, therefore the organisational structure did not begin to take shape until the 1990's in some health board areas. The development of the profession has also been limited by loss of therapists. Surveys and feedback from working parties have identified various factors which contribute to this wastage. These include the following stressors:- working with large caseloads and long waiting lists, limited opportunity to develop specialist skills, lack of interdisciplinary team structures and insufficient support structures ranging from inadequate accommodation to lack of access to secretarial services. Pay and working conditions have also been highlighted as factors limiting the development of the profession. There is limited opportunity for career development. Levels of pay are low in relation to professional responsibilities. There is limited flexibility of working patterns (e.g. job-sharing) which militates against an almost all-female profession.

1.3 Communication

To understand the domain of speech and language therapy and the expertise required by practitioners of the profession, a necessary starting point is a description of that aspect of human behaviour with which the therapist is principally concerned, i.e. communication.

Communication is a most complex aspect of human behaviour through which we form relationships and maintain contact at every level of community and society. The exchange of information and ideas across a huge variety of contexts is central to the human experience. Communication permeates every stage of our existence and is fundamental to the development of our potential as individuals. Our progress through life, from forming our earliest family relationships, through receiving an education and developing our vocational and social lives, is underpinned by our ability to communicate. Hence a communication disability, depending on its severity, may have a very significant impact on the quality of our lives.

Our chief means of communication is via oral and written language. Language may be described as a code of conventional symbols which represent ideas. This code or language consists of an inter-related set of components and aspects.

Language Form: Each language system, whether it be oral, written, sign, etc., has its own set of symbols and rules which determine the structure or form of that system. The form of oral language consists of speech sounds (vowels and consonants) which combine to form meaningful units (morphemes, words) which are then combined in a particular order to form larger units - sentences (syntax).

Language Content: Refers to what we talk about, or the way in which our structures (words and sentences) are endowed with meaning.

Language Use: Refers to the pragmatic role of language, or what we make language do for us. We use language in a wide variety of settings and to perform a broad range of tasks such as asking questions, making statements, giving commands, etc. The way we use language has a major impact on our effectiveness as communicators.

Although the vast majority of people use oral language as their chief means of communication, this may not be possible for people with very severe communication impairments, as in certain cases of hearing impairment, mental handicap, or physical disability. In these situations, alternative or augmentative communication methods may be used to fulfil communication needs. These methods include technological aids (e.g. hearing aid, computer), manual signing and symbol systems.

A thorough understanding of the processes of communication is central to the speech and language therapist's work. The state of knowledge regarding human communication is constantly expanding and being continually informed by research in the fields of neurology, oncology surgery, education, psychology, family therapy and linguistics, as well as

by speech and language therapists' own research. Because of the rate of development of scientific knowledge, the speech and language therapist is required more than ever to expand her knowledge base in her quest to identify, prevent and intervene in disorders of communication.

1.4 Disorders of Communication

The form, content and use aspects of language described above are not discrete entities but combine in a highly inter-related and inter-dependent manner. Thus when a speech/language disorder exists, the entire process is more likely to be affected than just one single domain. Similarly, because of the broad ranging nature of the communication process, communication disorders have widely differing presentations, associated with a diverse set of aetiological factors. These aetiological factors may be grouped according to whether they are:-

i) *Congenital* i.e. present either before or from birth e.g. cleft lip/palate, cerebral palsy, Down's syndrome.
ii) *Developmental* i.e. become apparent in early childhood and manifest as a generalised or specific developmental problem e.g. slowness to acquire language, stuttering.
iii) *Acquired* i.e. as a result of illness/injury e.g. stroke, head injury, cancer of larynx.

Communication disorders affect all age groups but are much more common in children than adults. They range in degree from mild to severe. Enderby (1989) defines these terms when she uses "severe" to refer to "persons who have difficulty in making themselves understood by anyone other than their immediate family. This group also includes those who are non-vocal. The term "moderate" includes those persons whose speech defect is noticeable to the lay person, but who may nevertheless remain intelligible".

While it is important to remember that the symptoms of speech/language disorders are more likely to span the three aspects of form, content and use, for ease of description they will now be briefly outlined according to the predominant aspect affected.

Disorders of Pronunciation: Articulation/phonology: affect the ability to produce speech sounds and words accurately. This results in speech which is indistinct and is some cases, unintelligible.

Disorders of Comprehension: affect the ability to adequately understand the meanings of words and sentences. These can range from slight difficulty in understanding what is said to an almost total lack of comprehension of spoken language.

Disorders of Expression: affect the ability to use appropriate vocabulary and grammatical structures for meaningful expression. These may range from mild e.g. slightly immature grammar to severe e.g. extreme difficulty in recalling particular names/labels or inability to sequence words into even simple sentences.

Disorders of Pragmatics: affect the interactive aspect of language resulting in reduced effectiveness in getting one's message across appropriately. Often there is poor conversational ability (e.g. either failure to participate sufficiently or, conversely, monopolising the conversation and being "long-winded"). Interpretation of words may be over-literal (e.g. failure to grasp humour, idioms, metaphors, etc.) In more severe cases there may be very little use of language to communicate with others (e.g. autism).

Disorders of Written Language: affect reading, writing and spelling ability to various degrees.

Disorders of Voice: affect the production of voice and may involve problems with vocal quality, pitch, intonation, resonance and volume. They may range from mild hoarseness to complete and permanent loss of natural voice e.g. removal of the larynx due to cancer.

Disorders of Fluency: disrupt the normal rhythm, pace and flow of speech e.g. stuttering and cluttering.

In addition to disorders of communication, speech and language therapists have a role in the identification and management of disorders of swallowing. These occur when the primary functions of the organs of articulation (i.e. eating, drinking) are compromised by an impaired swallow mechanism (e.g. clients post stroke or those with cerebral palsy or cleft palate) and choking or aspiration of food and fluids may result.

1.5 The education of speech and language therapists

The education of speech therapists did not begin here until 1969 with the establishment of the Dublin College of Speech Therapy. DCST was run under the auspices of the National Rehabilitation Board with Sr. Marie de Montfort as director. At that time the annual intake of students was 15 and the course was of three years duration. The first graduates qualified with a Diploma in Speech Therapy allowing them to apply for the Licentiate of the College of Speech Therapists (London).

In 1977 the diploma course at DCST assumed degree status and graduates were awarded an Arts (Letters) degree from the University of Dublin, Trinity College. The School of Remedial Linguistics was instituted as part of the Arts Faculty in 1979 and it became the School of Clinical Speech and Language Studies, moving into the Faculty of Health Sciences in 1985. The annual intake of students has gradually risen over the years: in the 1980's the average intake was 20 and in 1992 it rose to 26, under direction from the then Minister for Health, Dr. O'Connell.

Until 1992, the course undertaken by students was monitored and accredited by the professional body of speech and language therapists in the UK, the College of Speech & Language Therapists (CSLT). Following EC directives on professional qualifications, the Irish Association of

Speech and Language Therapists (IASLT) has taken over this role of professional accreditation.

1.6 Education at undergraduate level

Education for speech and language therapists in the Republic of Ireland takes place in the School of Clinical Speech and Language Studies, Trinity College, the University of Dublin. The course is of 4 years duration and leads to a B.Sc. Honours degree in Clinical Speech and Language Studies. The course is part of the Faculty of Health Sciences at the university and students participate in a range of courses offered to members of other disciplines. There is reciprocal recognition between the Dublin course and courses in the UK recognised by the College of Speech & Language Therapists (CSLT).

Entry

Entry to the course is through the CAO system, together with an assessment of speech and language skills. While candidates are required to fulfil specific pre-entry requirements, in reality the Leaving Certificate achievements of candidates far exceeds these requirements. For example, minimum requirements are that candidates will have achieved a pass level in higher Leaving Certificate English and one other language as well as having at least one Science subject. The entry achievement of candidates in 1991 was: 4 Bs and 1 C (or higher) in higher Leaving Certificate papers.

Aims

The aim of the course is to ensure that students graduate with a good basic knowledge of normal speech and language development, disorders of speech and language, both acquired and developmental, together with an understanding and personal experience of the application of this knowledge to clinical practice. A knowledge of the major disciplines related to the practice of speech and language therapy is also a focus of the course. Since the scope of speech and language disorders has expanded vastly in the recent past, it is impractical to attempt to cover all areas in depth during undergraduate courses. Students are encouraged to pursue studies at post-graduate level in relevant areas and at appropriate stages during their professional career. Areas requiring greater input at undergraduate level include use of computers for clinical and administrative purposes.

Clinical education

The clinical education of students takes place in a variety of settings. In the on-site clinic in Pearse Street students are involved initially in observation of clinical work and as the course progresses over a period of several months, they take on limited responsibility for treating clients under supervision. The recent appointment by the E.H.B. of a full-time therapist to service this clinic will greatly increase the variety of clinical experience available.

Block placements

At the end of first year, students participate in short block placements in clinics under the supervision of qualified therapists. During the summer vacation students in the second and third years of the course spend a four week period in block clinical work under supervision and in the fourth year of the course, students spend two five week periods in clinical blocks. Therapists in Ireland contribute greatly to clinical education by providing supervision and in this way support the professional development of students. Some placements are also available in the U.K. and U.S.A. Currently there is an acute shortage of clinical placements. This situation arises from a variety of factors including lack of adequate accommodation in clinics and the shortage of speech and language therapists generally. At present there is no statutory obligation on clinicians to accept students for clinical work and no remuneration for doing this work.

Validation of academic content of the education programme is carried out by Trinity College. Accreditation of the programme as a professional course is the function of the IASLT Education Board since 1992.

E. C. Directives 89/48

The E.C. directives refer to a general system for the mutual recognition of courses of at least 3 years duration. They facilitate the freedom of movement of professionals within member states. The Minister for Health is the designated authority with powers to determine if a substantial difference exists between the qualification of an applicant and that required in the host member state. Where a substantial difference is deemed to exist, applicants may be required to undergo an aptitude test or an adaption period, depending on the applicant's decision.

The directives refer to a competent authority which issues awards or recognises the qualification. The School of Clinical Speech and Language Studies agreed to act as the competent authority until such time as the Education Board of the I.A.S.L.T was ready to assume this responsibility.

Erasmus: the European Community action scheme for the mobility of university students

The School of Clinical Speech & Language Studies currently operates within a limited agreed Erasmus scheme, facilitating the exchange of students of speech & language therapy within the E.C. This movement is dependent on the recognition of equivalency between elements of courses taught at the different educational institutions. At the moment, equivalency of entire courses is only recognised between a limited number of states (e.g. between Ireland and the U.K.).

1.7 Post-graduate education

Opportunities for post graduate education leading to higher degrees in areas directly related to speech and language studies in the Republic are limited to:

1. M.Sc. & Ph. D. degrees by research;
2. M.Phil degree - part taught/part research;

These degrees may be attained in Trinity College.

Short occasional courses are also available for updating on recent advances in various areas and for in-depth further specialist education.

Summary

In this introductory chapter, a context for reviewing the speech and language therapy profession and its work is established. The roots of the profession in Ireland are traced and the growth of the profession from the 1950's described. Factors which have hampered expansion are identified. The complex nature of communication and its central role in our lives is briefly described, and the major types of communication disorder outlined. Finally, the educational process of speech and language therapists is described.

CHAPTER TWO

THE ROLE OF THE SPEECH & LANGUAGE THERAPIST AND THE THERAPY PROCESS

2.1 Overview of role

2.2 Assessment and diagnosis

2.3 The therapeutic role

2.4 Training and education

2.5 Prevention

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2.13 Diagnosis

2.14 Intervention

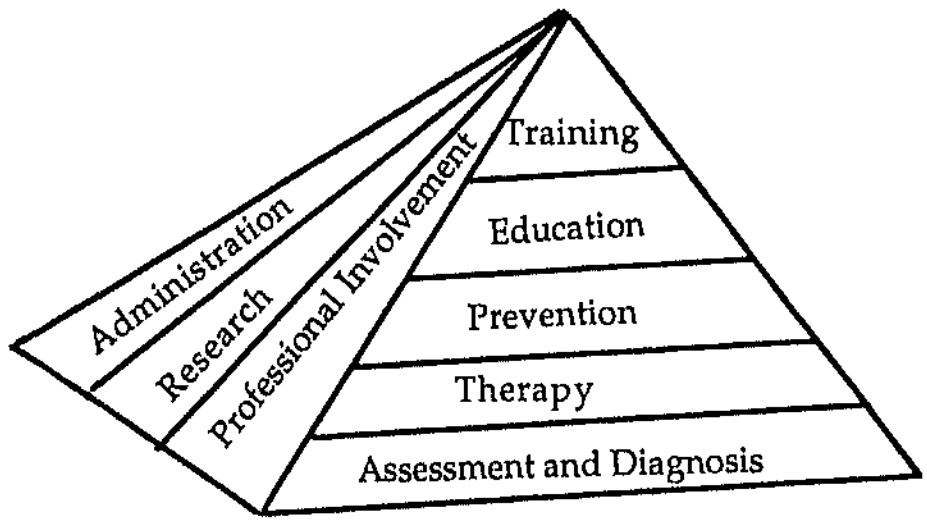
2.15 Evaluation

2 THE ROLE OF THE SPEECH & LANGUAGE THERAPIST AND THE THERAPY PROCESS

This chapter describes the professional and expert role of the speech and language therapist with regard to clinical and professional responsibilities; and the operation of the therapy process with clients with disorders. Currently, the major role of the therapist is in maximizing the interpersonal communication of clients. In pursuing this objective, many different professional activities are encompassed. Particular activities will vary according to the nature of the disorder being treated, the client group being served, the work setting and the level of responsibility attached to the speech and language therapy post. However, a number of core functions may be identified which are common to all therapists.

2.1. Overview of role

Fig I



2.2 Assessment and diagnosis

The initial contact with a client involves assessing the degree and the impact of the presenting disorder on communication and its effect on those in the client's immediate environment. This may be done in collaboration with members of other disciplines or in some instances, by the speech and language therapist alone. Where speech and language disorders are concerned the speech and language therapist has autonomy in defining and determining the diagnosis. A range of assessment procedures may be used depending on whether the assessment is for screening or diagnostic purposes. This is further elaborated in the *Process* section below.

2.3 The therapeutic role

The therapeutic role of the speech and language therapist encompasses the assessment, diagnosis, management and prevention of disorders of communication within the community. This role applies to all age groups from infancy (e.g. working with hospital staff and parents regarding feeding difficulties) to old age (e.g. working with elderly stroke patients). In addition to the direct role with clients, the therapist involves significant others from the clients' communicative environment in the process. This may include parents, spouses, families, carers and teachers who may receive information, support and counselling regarding the clients' condition and needs. The therapist may help in establishing support groups e.g. laryngectomy or stroke groups.

The speech and language therapist may work either directly with an interdisciplinary team or may liaise with other professionals involved with the client's care in drafting a joint treatment plan and carrying it through. Sharing information and expertise with team colleagues is seen as an essential component in catering to the totality of the client's needs.

2.4 Training and education

The speech and language therapist working in various settings will be involved in the training and education of others including student therapists, members of other professional disciplines and spouses or parents.

Supervision of undergraduate students on clinical placement is an important feature of the experienced speech and language therapist's work. In this role, the therapist acts as a teacher, demonstrator, and in many instances as co-examiner of students. In so doing, the therapist serves as a major resource and support system in the education and professional development of the student.

The speech and language therapist is involved in the in-service education of other disciplines such as medical, nursing, teaching, psychology and care staff with regard to communication and eating/feeding disorders and their management.

Undergraduate and post-graduate students from related disciplines e.g. medicine, nursing and education may require information from speech and language therapists about communication disorders. The team roles of members from different disciplines may be elucidated and promoted by involvement of different disciplines at an early stage in their education. Further, multidisciplinary awareness of roles and functions may serve to be both preventive and facilitatory for those with communication disorders.

2.5 Prevention

It is highly desirable that the incidence of communication disorders be reduced and where already present, that their impact on people's lives be minimised. The speech and language therapist's preventive role is of major importance. This role may be realised via education of the general public and targeting specific health, education and community personnel

e.g. public health nurses, preschool teachers, Community Mothers Scheme etc. Prevention campaigns are applicable to both child and adult populations in the detection of risk factors, addressing queries about referrals and by providing instruction, guidance and intervention strategies where feasible. This would be especially relevant in stimulating communication development in young children and by providing instruction in oral/laryngeal hygiene for the at-risk cancer population.

In general, therapists should be involved in promoting awareness of potential problems and raising consciousness about services and improvement possibilities, as well as utilising voluntary and other health agencies in the training and education of others.

2.6 Administration

A significant proportion of the speech and language therapist's time is spent in administrative duties. These will relate to direct client care (e.g. record keeping, report writing) as well as to wider issues of service organisation and development. Employing authorities need to be informed on a regular basis regarding particular service needs. Standards of service and how services are delivered require constant monitoring and evaluation. For these purposes, it is important that senior speech and language therapists become involved in the collection of epidemiological data as well as using statistical data to evaluate service delivery effectiveness thereby monitoring services adequately. Policy development needs on-going attention regarding models of care, methods of service organisation and service development. If speech and language therapy services are to grow towards meeting the needs of our population it is vital that the administrative role of the therapist is given due recognition and weight by both employing authorities and therapists themselves.

2.7 Research

The research role of the speech and language therapist is underdeveloped. There is a great need to collect and deseminate reliable scientific information on communication disorders in this country and the speech and language therapist is ideally placed to do this. Adequate time, funding, organisation and resources need to be provided to encourage this important activity.

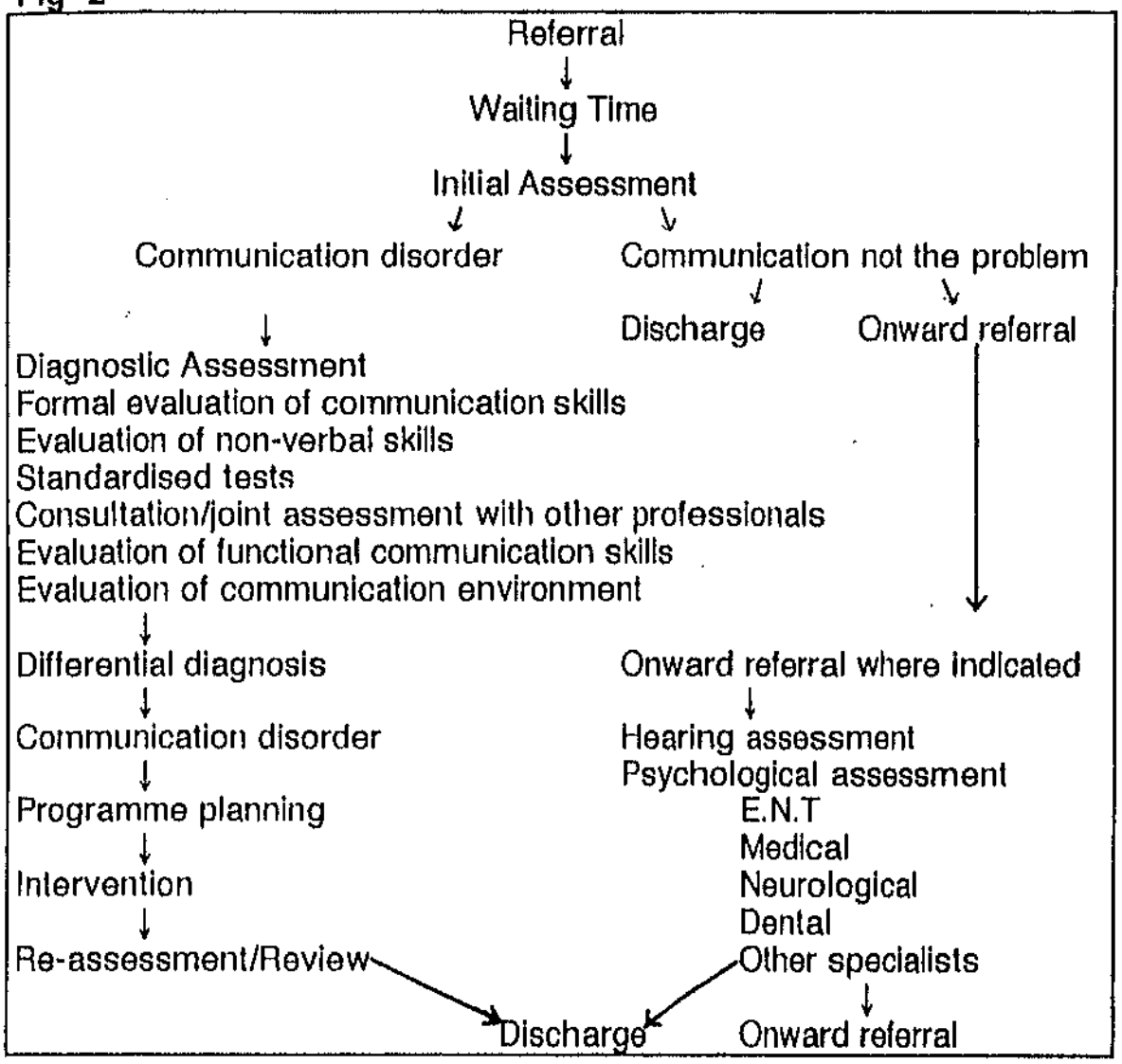
2.8 Professional development

Professional development is both a duty and a right of individual therapists. The science of intervention in disorders of communication is constantly evolving, requiring continuous updating of knowledge and skills. Reading current academic literature, attending lectures, courses, workshops and conferences, membership of special interest groups and professional organisations are all relevant but may be costly in time and financial terms. Employers need to be encouraged to support the professional development of speech and language therapists.

THE SPEECH AND LANGUAGE THERAPY PROCESS

2.9 Overview of therapy process

Fig 2



A client's involvement in the speech and language therapy process begins when first referred for service and concludes with discharge from the service. A sequence of stages occurs within this process which includes: referral, assessment, diagnosis, intervention, reassessment and discharge. The timing of each stage varies according to the type of disorder, the client group and the work setting.

2.10 Referral

Referrals to speech and language therapy emanate from a variety of professionals and carers e.g. public health nurses, doctors, teachers, psychologists, social workers, parents and self referrals. Criteria for accepting referrals will vary from agency to agency and will depend on the client group being served and the type of service being offered i.e. whether the speech and language therapy service is primary, secondary or tertiary to other services offered.

Where a communication disorder is associated with a medical condition, referral by a medical doctor is essential. Examples of such conditions include: stroke, head injury, cerebral palsy. vocal cord pathologies, Parkinsonism, cleft palate/ maxillo-facial anomalies and swallowing disorders.

2.11 Waiting time

Current demands on service necessitate this in the speech and language therapy process. Time spent on waiting lists varies according to the setting and available resources. In some acute hospitals or rehabilitation centres, assessments are offered within 2/3 days of receipt of referral whereas in other centres, time spent on the waiting list may extend to two years.

2.12 Assessment

The client's first direct contact with the speech and language therapist will generally be for initial assessment, the purpose of which is to determine the presence or absence of a communication disorder. Several types of informal and formal information are collected, including a case history providing background information. Communication skills are assessed via a collection of standardised, formal and informal measures. A physical examination of the oro-facial area is required in some but not all presenting conditions. Further assessment may be done in some instances aided by special technology e.g. videofluroscopy, nasometer and computer programs. In-depth interview techniques e.g. that developed by Rustin (1987) and specific linguistic analyses, may also be used.

Since communication is the chief means of social interaction, an evaluation of the client's communication environment, via discussion with family and carers is essential. This is both to determine the impact of the disorder on the client's life and to gauge the role which significant others will play in the therapeutic process.

Following the initial assessment, it may be decided that communication is not the major problem and the client may be discharged or referred on to a more appropriate service (where one exists) to determine the nature and extent of the problem.

Additional information may be required from other professionals to assist in arriving at a conclusion regarding the nature of the client's disorder. Examples of such information include an ear, nose and throat examination, audiological assessment, psychological assessment, neurological evaluation. There may also be joint assessments in some settings e.g. cleft palate team assessment clinics, centres for people with a mental handicap, dysphagia assessments.

2.13 Diagnosis

Information gathered through assessment procedures is interpreted to make clinical judgements about the presenting communication disorder

with specific reference to the client's relative strengths and weaknesses. This information is formally recorded in the client's file and a report is provided to the referral source. Assessment information is evaluated and used for planning therapy objectives and later for measuring progress. The nature of the condition is explained to the client and/or family/carers and a general prognosis may be estimated.

2.14 Intervention

This phase of the therapeutic process follows on from the preceding diagnostic phase and involves a programme of therapy or a management plan being agreed with the client/carer. This includes the setting of specific goals. The actual type of intervention will depend on a number of factors including the type of disorder, the client group and the work setting. Therapy may be done *directly* with the client (e.g. a client with a stroke, a child with a disorder of articulation) or *indirectly*, where the speech and language therapist works mainly with parents (e.g. a preschool child with normal nonfluency), or possibly other family members (e.g. with adult acquired disorders), or with the environment itself (e.g. in long-stay/day hospitals where facilities may be altered to promote communication).

Intensive therapy (i.e. daily work with a client) may be required for those with severe communication disorders. Such instances include the following: clients with head injury in a rehabilitation centre; people who stutter attending a two week fluency programme; children with severe language disorder attending a special unit.

Non-intensive therapy (i.e. once weekly or less) is generally offered to clients with less severe disorders. Both intensive and non-intensive therapy may be appropriate for some clients at different stages of their involvement. It is not unusual for clients to begin therapy with relatively intensive work followed by a period of less intensive involvement.

Therapy may be delivered either on an *individual* or *group* basis, or in some settings, both may be appropriate at different times. **The type, duration and intensity of therapy are determined by the speech and language therapist in relation to the needs of the given client at a given time, and cannot be decided on the basis of type of disorder or client group alone.**

Consideration should be given to other relevant services which may be of benefit to the client e.g. the client with a stroke may be referred on to a Volunteer Stroke Scheme. Different types of intervention as described need to take account of the client's social/education context and accordingly the client's significant others should be included in the therapeutic process.

The speech and language therapist may work in direct association with other professionals in providing some kinds of therapy e.g. group therapy, parent training workshops, intensive therapy.

2.15 Evaluation

At regular intervals throughout intervention the speech and language therapist will re-assess the client with regard to measuring change, evaluating the efficacy of therapy and making appropriate decisions about the client's future needs e.g. a further involvement in therapy followed by a review.

Discharge from therapy is effected under varying circumstances. Ideally this occurs when the goals of therapy have been met and the client no longer requires the services of the speech and language therapist. Failure to attend appointments or lack of co-operation may necessitate discharge.

Summary

This chapter describes the range of possible clinical and professional roles and responsibilities of the speech and language therapist. While some roles are well-defined, others have not been developed sufficiently, a major case in point being the research role of the therapist. The process of therapy is outlined along with various forms and formats of intervention. The speech and language therapist's autonomy with regard to decision-making in the speech and language therapy process is emphasised.

CHAPTER THREE

CLIENT GROUPS

3. CLIENT GROUPS

This chapter outlines the delivery of service to a range of client groups. It aims to outline briefly the needs of each group and describe how these are currently being met. Shortfalls in current service delivery are identified and suggestions made about developments needed to improve the service in the future.

3.1 Developmental Speech and Language Delay

3.1.1 This term is used to describe children who are not acquiring language with an age appropriate developmental pattern. They form a large proportion of the caseload of community care speech and language therapists. Incidence and prevalence studies in England and Ireland would indicate rates of 6% - 14%. (Supple 1980; Leahy 1986; Enderby and Davies, 1989)

Children presenting with such delays are usually referred to speech and language therapy services in Community Care Clinics, Child and Family Centres and Voluntary Agencies. The main referral sources are Public Health Nurses, Medical Officers, General Practitioners, Teachers and Parents. Delays in the development of speech and language require detailed assessment and intervention programmes to ensure that communication skills are maximized as early as possible. Early intervention programmes are essential in order to prevent secondary difficulties arising in particular in the socio-emotional and educational areas. Diagnosis and intervention with children who are experiencing communication failure will of necessity involve family/carers and teachers. Therapists working with these clients must also undertake education and training of parents and other professionals on a formal and informal basis.

3. 1.2 **Shortfalls in service delivery**

a Long waiting lists results in many children with delays in language development not being assessed or offered therapy as early as they should.
Periods of up to two years may be spent on waiting lists in some areas where services are poorly developed. This can compound parental anxiety and the delay in development may also have negative effects on the children's development in social, emotional and educational areas.
Long waiting lists in some areas may have also resulted in masking needs with this client group, as therapists report referral sources informally prioritizing referrals ie. referring what they perceive as urgent cases only while at the same time informing the therapist that other children will probably require therapy, but 'as they may grow out of it we will leave them till next year'.

b Inadequate support systems - limited availability of interdisciplinary teams in settings where many of these children attend for therapy may often result in areas of need not being fully met. The lack of appropriate support systems to maximize benefit from therapy may result in demands on therapists to become involved in issues which would be best dealt with by other team members e.g.. teachers, psychologists, social workers etc. While this may be necessary to best serve an individual client it does not result in a better service for the client group.

c Limited opportunities/structures to allow for the education and training of parents/carers and other professionals within current structures and settings.

d Lack of formal liaison with the Educational System: Currently, liaison between teachers and therapists occurs on an informal basis and are usually focussed on the needs of individual children. Therapists have no official status within schools and their involvement in planning curriculum development and class room programmes is limited.

3. 1.3 **<u>Developments needed to improve the service</u>**

a. Research Programmes to allow prevalence rates of delayed speech and language development to be estimated in Ireland.

b. Education of main referral sources in order to ensure appropriate referral.

c Development of structures which would support and facilitate education programmes for parents and others working with these children.

d. Establishment of formal links with the Department of Education to facilitate team work at primary and post-primary levels.

e. Co-operation between voluntary agencies and community care in order to estimate the needs of this client group in their areas, to agree on responsibility for these children and to adjust staffing levels appropriately.

f. Research programmes to identify the effectiveness of the various therapy delivery options with this client group.

g. Development of an early language screening test for use by public health nurses, doctors etc to ensure early referral.

3. 2 Children with Specific Language Impairment

3. 2.1 Children in this client group present with speech and language difficulties where skills are not developing in line with expected developmental sequence. Specific deficits may occur in any or all areas of prelinguistic/linguistic skills and the children may present with difficulties in comprehension, expression or use of spoken or written language. These children will require intensive intervention at both pre-school and school level if they are to develop adequate communication skills. Early identification and intervention with children with specific language impairment is essential for growth and development of linguistic skills. Intervention needed will be determined by the type and extent of

the disorder, but the need for intensive individually tailored programmes is shared by all. These children currently attend for therapy in special language units and language classes where therapists and teachers can work together to develop specific skills, while also ensuring that educational needs are met.
Unfortunately language units and classes cannot provide a service to all those identified and waiting lists are in operation. The development of units and classes is uneven across and within the Health Boards and Community Care Areas hence some children may not receive the appropriate service.

3. 2.2 **Shortfalls in service delivery**

a. Children with specific language impairment are identified in many cases via Community Care Clinics and other services dealing with children with language delay. The long waiting lists for these clinics plus the additional waiting time following diagnosis may result in unacceptable delays before remediation programmes can begin.

b. Prioritization criteria in operation have resulted in a focus on younger children with the needs of the older child with specific impairments in language unserviced.

c. Lack of formal structures to facilitate the necessary team work between Education and Health has limited the planning and development of services.

d. The uneven provision of language units and classes results in services being inaccessible to some children. This can result in some children being inappropriately placed e.g.. in mental handicap services or special schools where their special language needs can not be met.

3. 2.3 **Developments needed to improve the service**

a. Research to identify the population requiring specialist intervention for specific language disorders at different age levels e.g. Pre-school, Primary, Post-Primary.

b. Liaison and agreement on responsibility for service planning and delivery between Health and Education, and between statutory and voluntary agencies.

c. Research to develop screening tests to facilitate early identification of this client group.

d. Development of further special language units and classes where numbers indicate that the needs of this group are not being met.

3.3 Mental Handicap - Learning difficulties (moderate/severe)

3.3.1 Children and adults with learning difficulties (Mental handicap) experience a wide range of communication disorders. Estimates for those with disorders in communication vary from 50%. (Enderby and Philipp,1986; Enderby,1989) to 75% (Parker and Liddle, 1987). Irish studies (1989) would support the higher figure with prevalence rates of 71%. Children and adults with learning difficulty require in-depth assessment by an

interdisciplinary team to establish the degree and extent of communication disorder related to other areas of development. Intervention programmes need to be delivered with sufficient intensity to ensure that skills are developed and also need to focus on the communication environment of the client. Therapists working with this client group need to develop expertise in many specialist areas in order to provide a service to meet the varied needs of the group. Involvement in early intervention programmes requires special skills in counselling, education and teaching of parents/carers. Specialist skills in the following areas are also required - feeding / eating/dysphagia; augmentative/alternative communication, teaching/training of family and co-workers.

The needs of this client group are described in greater detail in *Communication Needs* (1989), a discussion document examining needs and services in 1989. The levels of service and the difficulties outlined in that document have not changed significantly in the past three years.

3. 3.2 **Shortfalls in service delivery**

a. Long waiting lists in both voluntary agencies and community care clinics resulting in clients often not being seen at optimal times for intervention.

b. Prioritization/exclusion criteria in community care clinics appear to discriminate against clients with a mental handicap not only on the grounds of initial handicap, but in some areas, age, school placement, cause of handicap may also be used e.g. children with a mental handicap attending local Nationals Schools not being eligible for referral, or children attending special schools may be excluded. The above example can occur in two adjoining community care areas of the same Health Board. Adults with learning difficulties are excluded from lists in many areas

c. Lack of interdisciplinary teams within the community care structures may result in therapists being unable to provide a comprehensive service to clients with a mental handicap.

d. Lack of input from speech and language therapists on a formal basis into the development of services in special schools and, special hospitals has resulted in limited planning in these settings and restrictions on the therapist's role in service planning and delivery.

e. Community Care speech and language therapists are coming under increasing pressure to provide a service to clients with a mental handicap, as educational and social integration is promoted. The following were identified as factors hindering this development:

(i) Resources not available for therapists to acquire specialist skills;
(ii) Interdisciplinary supports unavailable;
(iii) Unable to meet needs as suggested in *Needs and Abilities* (1990) e.g. domiciliary visits not possible at 0-3 years because of cutbacks on travel;
(iv)Lack of formal status in schools and special hospital programmes.

3.3.3 **Developments needed to improve the service**

a. Liaison between Health Boards and Voluntary Agencies to agree responsibility for service provision to this client group at an area level.

b. Development of Community Care Teams to provide a service to children and adults with learning difficulties.

c. Development of speech and language therapy structures within the special hospital and education structures which would integrate therapists in the teams in these programmes and facilitate service delivery and planning.

d. Increase in resources to allow major growth in provision for this client group because of the accumulated needs following years of minimal provision.

3.4 Physical Disability

3. 4.1 Approximately 40% of children and adults with a physical disability will present with communication disorders. The range and severity of disorders will vary from non-verbal to those with mild articulatory difficulties, but all will require specialist early intervention in order to reduce and minimize the effect of restricted motor ability on early communication and language development. Early intervention is also of importance to develop safe feeding/eating patterns in those clients whose physical disability results in difficulties in this area. Clients with a physical disability require long-term involvement as their needs change over life span. Currently infants and children with physical disability attend for therapy in Paediatric Hospitals, Voluntary Agencies and Community Care Clinics. Services may also be provided to special schools by therapists employed by the agencies above. Many of these clients will require specialist input from therapists in the areas of feeding/eating, augmentative communication as well as in neurodevelopmental programmes.

3. 4.2 **Shortfalls in service delivery**

a. Service to the client group is limited by inadequate staffing levels and uneven distribution of services.

b. Community Care Clinics often lack the full interdisciplinary team necessary to facilitate full development of the client.

c. Integration programmes allow children with physical disabilities to remain in their own geographical areas and this results in demands on therapists to develop specialist skills but provision of training and equipment is lacking.

d. Services to adults are undeveloped.

e. Augmentative communication aids may not be available to clients as in some areas these are considered to be suitable for sharing between users.

3. 4.3 **Developments needed to improve the service**

a. Development of comprehensive early intervention programmes with adequate staffing and support systems at a regional level.

b. Development of specialist resource centres to provide assessment and support to local team.
c. Involvement of speech and language therapists in education and training programmes for families and other professionals working with this client group particularly in the area of augmentative/alternative communication.
d. Development of specialist teams either within Community Care or Voluntary Agencies to liaise with general health services and education services.
e. Development of a service to adults with a physical disability in association with rehabilitation/vocational training programmes.
f. Recognition by Health Boards that communication aids where recommended for clients are essential to facilitate communication in all situations and therefore cannot be shared between users.
g. Recognition by the Department of Education that electronic communication aids may be considered primarily as an educational tool for some children and that funding should be provided for these through the education system.

3. 5. Sensory Impairment

3. 5.1 Speech and language therapy services for those with impaired vision or hearing are not well developed to date in Ireland.

Visual Impairment: Figures for prevalence of communication disorders in this population are not available, but reports from therapists involved in providing a service to this client group would indicate that approximately 20% require therapy to facilitate speech and language development.

Hearing Impairment: Data from the U.K. would indicate that approximately 60% of those with impaired hearing present with communication disorders. In Ireland currently a separate service is not provided to this client group - some may attend in Hospital Clinics, Community Care Clinics, others attend for private therapy. Children may attend in Community Care Clinics or Voluntary Agencies while adults may attend Hospital Clinics. Their needs however are seen as being primarily serviced by the educational services.

There is a need for liaison between health and education services to explore the need for more structured involvement of speech and language therapists with these client groups.

3. 6. Child and Adolescent Psychiatry

3. 6.1 Children and adolescents with psychiatric disorders present with a high incidence of communication disorders. Their needs are best met by a specialist multidisciplinary team where differential diagnosis is facilitated and a team approach to intervention followed. Early intervention is essential with these children to maximize communication within their environment and prevent the development of secondary problems due to communication failure. This preventive role will involve counselling and education

of family/carers. At present children with psychiatric symptomatology are seen in Child and Family Clinics, Community Care Clinics and Voluntary Hospitals/Agencies.

3. 6.2 **Shortfalls in service delivery**

a. Long waiting lists due to inadequate staffing resulting in problems compounded by lack of intervention e.g. challenging behaviours, educational difficulties, family stress.

b. Team supports may be lacking and this increases pressure on the speech and language therapy service.

c. Specialist psychiatric clinics have in the past provided a service to children with general speech and language delays and this has resulted in children with psychiatric symptomatology facing longer periods on waiting lists.

3. 6.3 **Developments needed to improve the service**

a. Provision of early intervention programmes and development of support services to facilitate early diagnosis and therapy.

b. Research to identify children who require specialist services because of psychiatric disorders.

c. Liaison with Community Care speech and language therapists to facilitate attendance of children with developmental delays at local clinics thus reducing pressure on specialist psychiatric services.

3. 6.4 **Adolescent/Adult Psychiatric Services**

Services to adolescents/adults with psychiatric disorders are not developed formally in Ireland. Service delivery to this client group will often occur via general hospital or community care clinics without the necessary team supports.
There is a need for research into the role of the speech and language therapist with this group in view of increasing moves towards community integration.

3.7 Autism

3. 7.1 Clients in this group are characterized by disordered communication. The needs of individual clients within the group will vary depending on the severity of the autistic features and the presence of related behavioural disorders and intellectual and/or sensory impairments. It is essential that differential diagnosis of these clients occurs in order to ensure appropriate therapeutic and educational intervention. Diagnosis and intervention are best served by an interdisciplinary team where the total development of the client is promoted. Children with disorders along the autistic continuum currently attend for integrated services in specialist centres for autism and mental handicap.

3. 7.2 **Shortfalls in service delivery**

a. The limited availability of multidisciplinary teams can result in delays in differential diagnosis and subsequent stress on the children and their families.

b. Inadequate speech and language therapy provision to centres providing a service to this client group can result in therapists involved in assessment only and a long waiting list for therapy.
c. Facilities for education/training of families and co-professionals in order to provide appropriate communication environments for clients are often lacking.
d. Services to adolescents/adults is extremely limited.

3. 7.3 **Developments needed to improve the service**

a. Resources to allow therapists working with these clients to develop specialist skills in counselling and education/training of others.
b. Increased staffing to allow for intensive therapy where indicated.
c. Research to determine role with adolescents/adults in vocational/life skills programmes.

3.8 Disorders of Fluency

3.8.1 Fluency disorders (stammering/stuttering, cluttering) are characterized by repetition of sounds and/or words, blocking and or prolongation. In addition, anxiety and negative emotional reactions associated with the stuttering itself and to communication in general are common in the person who stutters. The incidence of the disorder varies from 14% in children to 2% in adults (Van Riper, 1983). The disorder may be minor or severe in its manifestation but will adversely affect the client's ability to communicate. Children with fluency disorders attend for therapy in Community Care Clinics and Child Guidance Centres. Specialist knowledge of fluency disorders may be required for some kinds of intervention. Clients and families of children with fluency disorders benefit from counselling and group therapy and many derive most benefit from intensive therapy. Early intervention is necessary as anxiety may increase the severity of the disorder and result in negative social and educational outcomes.

3.8.2 **Shortfalls in service delivery**

a Long periods spent on waiting lists for assessment and therapy may increase the severity of stuttering in children.
b Services to adults with fluency disorders are limited because personnel shortages in clinics often result in children being prioritized.
c Intensive group programmes may be the optimal therapy method for some but this is often not available due to the shortage of therapists and the scatter of clients across different service locations.

3. 8.3 **Developments needed to improve the service**

a Increase in availability of therapy to children and adults.
b Case load research to determine incidence figures at different age levels and effective therapy programmes.

c Liaison between speech and language therapy departments in Community Care and Voluntary Agencies to develop centres with specialist expertise and to facilitate running of appropriate group therapy programmes.

3.9 Cleft Lip/Palate

3.9.1 Children born with a cleft lip/palate may present with disorders of articulation and/or resonance. They require a service from early infancy to monitor feeding and speech and language development and initiate intervention programmes as early as is necessary. These children require a co-ordinated team approach with medical and orthodontic staff. Service delivery occurs via specialist hospital clinics where multi-disciplinary teams are located and/or in Community Care clinics. Liaison and coordination between therapists in both Centres is of importance to ensure efficacy and prevent the development of secondary difficulties.

3.9.2 **Shortfalls in service delivery**

a Early intervention may not be available at a local level and travel plus pressure of diagnostic work in specialist clinics may also militate against offering families the support needed at the early stages.

b Pressure of numbers attending specialist clinics may limit availability of expertise.

c Liaison with speech and language therapists in the clients own area may often be difficult due to inadequate local services, long waiting lists etc.

3. 9.3 **Developments needed to improve the service**

a. Development of early referral systems to ensure support is available for parents at early stages, in particular in feeding.

b. Development of specialist clinics/peripatetic teams to provide a service both to clients and to speech and language therapists working in local areas.

c. Involvement in research programmes to identify efficacy of intervention strategies in the communication disorders of the child with a cleft palate.

d. Provision of training facilities for speech and language therapists to develop expertise in the use of objective measures in the assessment of oral/velopharyngeal dysfunction.

3.10 Ear, Nose and Throat

3.10.1 Clients with disorders of voice quality, resonance, pitch or volume are seen for therapy in hospital and Community Care Clinics. Close liaison with E.N.T. teams is essential in the management of voice disorders and early intervention is a priority in many clients, in order to prevent a more severe or chronic problem developing. Speech and language therapists also have a preventive role to play with groups who may be at risk of voice disorders because of

occupation. Clients undergoing head and neck surgery with partial or total surgical removal of the larynx require intensive therapy. Therapy should begin in the pre-operative stage with counselling and advice to both the client and carers. In the immediate post-operative period, the client may require further counselling and facilitation in the use of an augmentative communication system. Voice therapy will commence following liaison with the multidisciplinary team. Initial therapy is usually offered under hospital care, but follow up therapy may occur in Community Care Clinics.

3.10.2 **Shortfalls in current service delivery**

a. Inadequate staffing resulting in pressure on therapy time by large caseloads. This may result in restrictions on counselling and preventive therapy with negative consequences on later therapy.

b. Lack of planned service to adults with voice disorders in community care areas resulting in these clients needing to remain on hospital caseloads for longer than needs for specialist therapy demand. This results in further delays to those clients who are waitlisted for specialist intervention.

c. Case load pressures may result in waiting periods which may adversely affect those with voice disorders and result in the need for more therapy in the long term.

d. Resources to facilitate diagnosis and therapy programmes are unavailable in many clinics e.g.. facilities to allow objective acoustic analysis; microphones, communication aids, etc. for use with clients when needed.

3.10.3 **Developments needed to improve the service**

a. Involvement of speech and language therapists in prevention of voice disorders with at-risk populations.

b. Resources to be made available for therapists in Community Care Programmes to acquire the necessary skills to work with these clients.

c. Resource centres with aids to facilitate communication following laryngectomy, head/neck surgery to be developed in Health Board areas.

d. Closer liaison between hospital and community care teams in order to facilitate transfer of clients and adequate follow up.

3.11 Acquired Neurological Disorders

3.11.1 Neurological damage following brain insult or injury results in some degree of communication disorder in approximately 30% of clients. The disorders presented by this client group can vary from global loss of verbal language both spoken and written to difficulties with speech sound production. Eating and swallowing disorders may also occur. Service delivery to these clients takes place primarily in hospitals and rehabilitation units. Adults with acquired communication disorders need a detailed assessment to

identify the skills that are present, those that are lost and their current functional communication skills. The use of objective assessments is necessary to complement informal assessments and facilitate diagnostic, prognostic and therapeutic decision making. Decisions on intervention must take place in an interdisciplinary team to ensure that co-ordinated cohesive and appropriate intervention programmes are offered.

The speech and language therapist also works with family and carers in order to enable them to maximize communication at acute stages and facilitate remediation.

3.11.2 **Shortfalls in service delivery**

a. Service to adults is often limited and may exclude some clients for physical reasons e.g. lack of appropriate transport, limited accessibility of clinic rooms, lack of accommodation for group therapy.
b. Hospital clinics may only offer limited out-patient services because of pressure of acute case load.
c. Hospital clinics may also have difficulties in transferring clients to local services or rehabilitation centres thus resulting in increasing pressure to keep clients within the hospital services.
d. Access to specialized rehabilitation units on discharge is difficult because of inadequate resources in these units resulting in prioritization criteria which may exclude clients on grounds of age, severity of disorder, etc.
e. Facilities for therapy in local community care areas are undeveloped with a limited service only offered to the adult population. The service to those with accompanying physical disability is further restricted by transport, access, and accommodation problems as well as a lack of appropriate assessment and therapy materials.
f. Lack of specialist staff and equipment to facilitate diagnosis/ intervention of those with eating/swallowing disorders.

3.11.3 **Developments required to improve the service**

a. Liaison between hospital and community care clinics to develop services for adults requiring rehabilitation in their own areas.
b. Additional resources to facilitate attendance for therapy, transport, clinic accessibility etc. Resources will also be required to enable domiciliary services to be offered where appropriate.
c. Development of specialist centres with interdisciplinary team structures and technical equipment to undertake full investigation and treatment of eating/swallowing disorders.
d. Research to be encouraged to facilitate the planning of a service to meet the needs of this population - identify numbers, types of disorders, intervention programme efficacy etc.

3.12 Progressive Neurological Disorders

3.12.1 Clients experiencing progressive neurological disorders e.g. Parkinsonism, Motor Neurone Disease etc. which affect their communication and/or eating skills require therapy and/or support throughout the course of their disorder in order to maintain communication skills for as long as possible. Family and carers also benefit from support and advice to maximize communication. Therapy may involve the teaching of compensatory strategies in eating and/or communication at initial stages, or may require the provision of communication aids, and training clients and carers in their use.

3.12.2 **Shortfalls in service delivery**

a. Services to clients with progressive disorders are severely restricted with a limited service offered in hospitals, specialist centres and community care clinics.

b. Services offered tend to focus more on problems as they arise rather than on clients overall needs. Different agencies deal with individual aspects of problems after they arise e.g. dysphagia clinic for swallowing disorder, microelectronic centre for communication aid, community care for wheelchair.

c. Limited co-ordination between agencies involved in service provision.

d. Policies on provision of communication aids for clients vary greatly and procedures may, at present, take so long that the client may be dead before sanction is through.

3.12.3 **Developments needed to improve the service**

a. Research is urgently needed to identify the population suffering from communication or swallowing disorders as a result of progressive neurological disorders.

b. Current care programmes for this group need to be re-evaluated in the light of current trends towards community care, and adequate resources made available to the agencies responsible for service delivery.

c. Development of local resource centres where clients can be assessed, trained and supplied with communication aids on loan for the time needed.

3.13 Dysphagia

3.13.1 The term dysphagia is used to describe difficulties in swallowing. These difficulties may co-exist with neurological or orofacial disorders in children and adults e.g. children with cerebral palsy, cleft palate; adults post-cerebral vascular accident, or head/neck surgery. Dysphagia may result in inadequate/unsafe nutrition regimes and detailed diagnosis and intervention is necessary. Intervention in this area requires a specialist multidisciplinary team and in many cases the use of radiographic techniques is necessary to ensure that diagnosis and intervention programmes are promoting safe nutrition.

3.13.2 **Shortfalls in service delivery**

a. Limited development of specialist centres where a multidisciplinary team and technology are both available.
b. Rapid increase in demand on those centres which offer such specialist services has resulted in increased pressure on staff without any extra resources. This increase has resulted in a focus on diagnosis and has restricted time for intervention and follow up of clients.
c. Limited liaison between hospital clinics and community care therapists who may need to take responsibility for programme intervention.

3.13.3 **Developments needed to improve service**

a. Additional funding to develop specialist dysphagia clinics to serve both as a diagnostic service to clients and as a teaching service to professionals involved with this client group.
b. Liaison between specialist therapists and community care therapists to agree responsibility for service delivery.
c. Research to determine number of clients presenting with dysphagia in association with specific underlying disorders in order to facilitate future service planning.
d. Development of postgraduate courses to ensure that therapists can regularly update knowledge in this area of rapid growth .

Summary

This chapter provides a brief outline of how services to people with communication disorders are currently provided. It dentifies many shortfalls in services primarily due to inadequate resources. The 'right of access to services in accordance with need' stressed in the proposed Charter of Rights for hospital patients (Dept. of Health, 1992) cannot be guaranteed for many groups of clients with communication disorders. Some of the reasons for this denial of rights will be discussed in the following chapters.

CHAPTER FOUR

THE ORGANISATION OF SPEECH & LANGUAGE THERAPY SERVICES

4. THE ORGANISATION OF SPEECH AND LANGUAGE THERAPY SERVICES

In this chapter current structures underlying the delivery of speech and language therapy services are outlined. The service has developed under the Department of Health with speech and language therapists employed by Health Boards and Voluntary Hospitals/agencies. Service development has been affected by the many factors — social, political and economic — which have influenced health service development in general.

Changes in **social** values, with a commitment to integration for people with disabilities and the recognition of the entitlement to community-based services, have led to a variety of responses in terms of structures and services.

Political response to such changes has tended to be immediate and local, rather than strategic. In some cases this has led to pressure to provide services which may result in ineffective use of resources.

The single biggest factor affecting the development of speech and language therapy services is **financial.** Virtually all speech and language therapy posts are funded, directly or indirectly, by the Department of Health, which continues to experience grave difficulties in funding its Healthcare Programmes. The growth in service continues to be slow, with chronic understaffing hindering the development of appropriate organisational structures.

These factors outlined above together with the lack of adequate research studies to examine the needs of those with communication difficulties has resulted in a service that is inconsistent and uneven across and within Health Board areas.

4.1 Health Boards

Service planning and management: The majority of speech and language therapists are employed directly by Health Boards to provide a service to clients with communication disorders. The service has been organised primarily under the Community Care Programme with General and Special Hospital programmes served by therapists 'on loan' from the community team.

The service is organised geographically on the basis of Community Care areas, and service planning and administration come under the brief of the principal speech and language therapist. The role in service planning may be difficult to fulfil because of the lack of clarity in relation to the status of speech and language therapists in community care structures (NESC, 1987). Therapists do not have a clear role at management level and their input into service planning is limited because of this.

4.2 Community Care

Community care speech and language therapy should be available to all client groups. However, the pressure of demand coupled with limited numbers of therapists has resulted in the exclusion of many client groups from access to speech and language therapy services in their own area (see 5.6 for Exclusion Criteria).

Trends in general health and education policies in recent years have resulted in increased demands on community care services. Those factors which have resulted in increased numbers of referrals to speech and language therapy services include:

a. Integration policies for those with learning difficulties and physical and sensory disabilities.;

b. Focus on care in the community for adults with neurological disorders, both acute and progressive;

c. Improved early screening, parental awareness of the importance of the preschool period in language learning;

d. Increased knowledge and skill base of speech and language therapists, and recognition of this by other professions, resulting in increased demands in many areas eg. dysphagia, augmentative communication.

These have not only increased caseload pressures but have also resulted in an increased demand for specialist skills within community care teams. Current grading structures do not allow for the creation/recognition of these specialist posts.

Speech and language therapists working in community care provide a service in a variety of locations including Health Centres, Child and Family Centres, Special Hospitals and Schools. Therapists experience particular difficulties in providing services within special hospitals and schools, which will be discussed briefly here.

4.3 Special Hospital Programmes

Speech and language therapists from Community Care teams providing services to Special Hospital Programmes experience difficulties due to conflicts and confusion in reporting/accountability relationships. Technically reporting to their community care principal therapist, their accountability to the clinical/medical director is also of importance. Ambiguities resulting from this situation often mean that speech and language therapists have minimal formal input into service planning or policy. Therapists working in such posts may be reporting to a principal who is not involved at all in planning decisions which can directly affect service delivery to clients.

4.4 Special Schools

Speech and language therapists from community care teams are under increasing pressure to provide services both to the special schools within their community care area, and to schools facilitating integration programmes. Therapists in these positions do not have a formal role in the school. Confusion about reporting/accountability relationships exist in these situations, and the therapist's unofficial role and status may result in minimal effective involvement in education programmes.

4.5 Relationship between the Departments of Health and Education

The majority of school-going children who are in receipt of speech and language therapy services attend Department of Education funded primary and secondary schools. Despite this, the Department of Education has no budgetary allocation for the provision of speech and language therapy within mainstream schools. Therapists working in special educational settings (special language schools, language classes, special national schools), are 'borrowed' from health care programmes - usually Community Care or the Special Hospitals programmes - or from a voluntary agency where the same agency is the patron of the school. The Department of Education does not fund this service — widely recognised as an **educational** provision for these clients groups — nor does it formally recognise the therapist in this setting. Speech and language therapists work closely with teachers in many settings, but the lack of recognition by the Department of Education of their role has obvious implications for the delivery of an effective service.

The Education Act (1982) in the U.K. formally recognised speech and language therapy as an **educational** provision. Speech and language therapy may be specified in a *Statement of Educational Need* and parents can sue Local Education Authorities for the provision of an appropriate therapy service where this is not provided. Speech and language therapists are routinely employed by Education Authorities in the U.K., in other European countries and in the United States and work with teachers within the educational system to provide an integrated service to those pupils who have communication disorders.

The Irish Association of Speech and Language Therapists urges the Departments of Health and Education to formally recognise and address the issue of the role of speech and language therapists in schools.

4.6 Voluntary Hospitals / Agencies

Speech and language therapy services in the non-statutory agencies have developed primarily as a response to the needs of specific client groups.

In voluntary hospitals the main focus has been on the needs of clients with underlying medical conditions - ENT, neurological - while the voluntary agencies have focused on those with specific handicaps and disabilities.

This situation has allowed centres of excellence and specialist clinics to develop, but access to them is affected by geography, catchment areas and limited budgets. Voluntary hospitals are also under pressure because of the lack of community based therapists with specialist skills who can continue services to patients on discharge from hospital. This difficulty in transfer from hospital to community care may result in patients spending more time than necessary in hospital, and has budgetary, as well as therapeutic, implications. Patients who do not receive adequate intervention, at the appropriate time, on discharge from hospital, may not only fail to make progress but may deteriorate.

4.7 Relationships between Health Board and Voluntary Hospitals / Agencies

The lack of a coordinated approach to health service delivery between the voluntary and statutory agencies has contributed to the uneven development of speech and language therapy services. Services to specific client groups may be duplicated in some areas while the same group may have no service in another area. This major difficulty has been discussed in detail in the NESC report (1987) and in the more recent report from the Dublin Hospital Initiative Group (The Kennedy Report 1990).

The Kennedy Report (1990) states: " The present structures are notable for the fragmentation of the health service, the confusion as to the roles and responsibilities of the various agencies and the lack of an effective overview of the interaction of services at levels of planning and delivery". Confusion about responsibility for service delivery has restricted development of services to those with communication disorders. The lack of co-ordination between statutory and non-statutory agencies and the competition for resources has resulted in minimal co-operation and restricted information sharing which limits attempts to provide a service to meet the needs.

4.8 Organisation of the Profession within Health Boards and Voluntary Agencies

The organisation of speech and language therapy services reflect the general policies of the employer. These policies have often developed in haphazard ways as immediate responses to a range of pressures, and in many instances, without consultations with professionals involved in service delivery. As a relatively new profession, speech and language therapists are often not represented at overall policy and planning levels within organisations. The IASLT questionnaire returns (1992) indicate that few speech and language therapists who took part in the survey (21% of respondents) are themselves part of the management team for their service and only 7.8% had this role specified in their job descriptions.

The lack of consultation may result in ill informed decision making directly affecting service delivery.

a Funding and Resources: decisions about the number of speech and language therapy posts, the provision of suitable accommodation, equipment budgets, support services and training are often taken without adequate consultation

b Service locations may be decided at management level without adequate information on client groups or specific needs. Geography may restrict access of clients to clinics — clients may be unable to attend a local clinic because of a lack of transport. Satellite clinics operating in an attempt to reduce these restrictions have been limited in growth in some areas by decisions reducing travel expenses paid to those providing a service in such clinics. Service locations may also restrict access because of physical conditions.
In common with many public buildings, the location and design of speech and language therapy clinics and other settings in which therapists work are often inaccessible to those with mobility difficulties. This group includes not only those with physical disabilities but also the very young, the very old and those using wheelchairs or pushing buggys. Physical features of the building can effectively exclude a client or groups of clients from access to speech and language therapy services.

c Admission policy: Clients in need of speech and language therapy services may be denied access as a matter of policy. Policies may be based on socio-economic level of the client, e.g. medical card holders only; age, e.g. school-age children only; client group, e.g. non-mental handicap only (see 5.5 and 5.6, Prioritization and Exclusion). Access may also be restricted through closed referral systems e.g. referrals accepted from ENT only.

d Specific client needs may be ignored e.g. intensive rehabilitation for patients with head injuries, suitable technology for alternative/augmentative communication and the need for inservice training to develop specialist skills may not be recognised or included in budgets.

4.9. Professional Structures

The growth of the professional role in service organisation and planning has been hindered by the present grading structure. This structure (see appendix 2) was recommended in 1979 when it was hoped that the number of posts would increase rapidly and it was therefore based primarily on number of therapists employed. The expected increase did not occur due to cutbacks in services in the mid eighties and consequently the creation of posts at principal level was delayed and in some health boards these were not formally ratified until 1992. The lack of recognition of the role of therapists in assessing needs and planning

services is reflected in the absence from management meetings and lack of input into budgets reported in the 1992 survey (IASLT). The grading structure has also limited development of the specialist services required to meet the needs of specific client groups. While it is possible for appointments to senior posts to be made on the basis of specialisation, this is extremely rare in practice. The grading structure does not technically allow for the appointment of a speech and language therapist to a principal post on the basis of specialisation, although this has happened in at least one case. This means that there is little incentive for a therapist to develop specialist skills and expertise, and little encouragement for employers to recognise the needs for, and support the development of, specialist posts. The lack of recognition of the demands of specialisation is reflected in the absence of formal requirements for experience and/or specialist training before engaging in full-time work in a specialised area (see *Communication Needs* ,1989 in relation to mental handicap). Thus, while speech and language therapists may be working as specialists in terms of skill, experience and caseload, this is not reflected in pay, conditions, status or indeed, job description or title.

Summary

This chapter identifies some of the organisational issues that have limited the development of an adequate speech and language therapy service. Issues both external and internal to the profession are outlined.

CHAPTER FIVE

PRESENT LEVELS OF SERVICE

5 PRESENT LEVELS OF SERVICE

This chapter reviews present levels of services to children and adults with communication disorders. It is based primarily on results of an IASLT survey carried out in 1992 and on the findings of speech and language therapists working parties. The IASLT questionnaire (1992) received returns from **149** speech and language therapists, of whom **145** were practising. Excluding **4** therapists working in a University setting, and **4** working privately, the returns represent **73%** of the **187** speech and language therapy posts identified by the Department of Health.

5.1 General Health Policies

The Department of Health has the responsibility for ensuring the provision of speech and language therapy services. This responsibility is discharged currently through eight Health Boards and through voluntary hospitals and other organisations. The Department of Health has not had a direct role in directing or supporting the development of speech and language therapy services, but it impacts on service provision in two ways:

through the overall funding provided to Health Boards, Voluntary Hospitals and other Voluntary Bodies

and

through its Personnel Section, which must approve the creation of all new posts, the regrading of existing posts and the filling of posts.

The absence of an overall set of agreed policies in relation to the provision and development of speech and language therapy services, combined with a serious overall shortfall in the provision of services, has led to great variation in the **amount** of service provided, and in the the provision of specialist services and services to particular client groups.The availability of the appropriate type and level of speech and language therapy to an individual client or patient is therefore closely linked to local, rather than national, policies, practices and priorities.

5.2 Current service provision

A review of Community Care carried out in 1987 by the National Economic and Social Council revealed that the numbers of speech and language therapists employed by Health Boards (by far the largest employer of speech and language therapists) ranged from 1 per 100,000 population (in the Southern and Mid-Western Health Boards) to 7 per 100,000 population (in the North-Western Health Board).

Enderby (1988) suggests that the minimum number of posts needed to provide an adequate service to a general caseload is **23.37 per 100,000 population**. She further suggests that a much higher ratio is required to ensure an appropriate service to special populations such as those with a hearing impairment or physical or mental handicap, who need more intensive or frequent intervention.

In the Irish context, a ratio of 23.37 Whole Time Equivalent posts per 100,000 general population, given a population of 3,500,000, suggests the need for some 818 (817.95) speech and language therapists .

The latest figures available from the Department of Health (Table 5.1.) indicate that there are 187 approved speech and language therapy posts.

TABLE 5.1: ***Employment of Speech and Language Therapists by Health Board Area at December 1991. (Figures from Department of Health)***

HB AREA	Number of SLTs	Whole Time Equivalents
EASTERN	39	33.15
SOUTH EASTERN	20	18.25
SOUTHERN	13	12.16
MID-WESTERN	14	14
WESTERN	15	15
NORTH-WESTERN	13	13
NORTH-EASTERN	7	5.48
MIDLAND	13	11.43
TOTAL HEALTH BOARDS	134	122.47
VOLUNTARY HOSPITALS	25	19.84
MENTAL HANDICAP HOMES	28	17.9
TOTAL SLT	**187**	**161.40 WTE**

TABLE 5.2: ***Breakdown of IASLT replies by employer (N=145)***

Employer	Number	%age
Health Board	88	60.7
Voluntary Hospital	13	9
Other Hospital	3	2.1
Voluntary agency	23	15.9
Self/Private	4	2.8
University	4	2.8
2 or more Employers	4	2.8
Unknown	6	4.1

5.3 Clinical settings

Speech and language therapy services are provided in all three programmes in Health Boards (general hospitals; special hospitals; community care), in special schools and clinics, in voluntary hospitals, in clinics and other centres run by voluntary organisations, and in private settings. However, in all but voluntary organisations and private settings most speech and language therapists are employed under Community Care Programmes.

The IASLT questionnaire (1992) sought information on the main or base clinic of the speech and language therapist, and on other clinical settings in which the therapist worked. The majority of respondents (58.2%) identified **community care health centre/clinic** as their main or base clinic. Table 5.3. lists the base clinical settings identified by respondents.

TABLE 5.3: ***Clinical settings (N=145)***

Base Clinic	%age SLTs
Health Centre/Clinic	58.2
Child and Family Centre	7.8
Hospital: General	7.8
Rehabilitation Centre/Unit	2.1
Long Stay/Special Hospitals	1.4
Developmental / Assessment Clinic	3.5
Private Hospital	0.0
Education: Preschool/Nursery	0.7
Primary School	2.1
Special National School	6.4
Day Centre: Developmental Day Centre	0.7
Adult Training Centre/ Workshop	0.7
University Clinic	2.1
Home/Private Office	3.5
Client's Home	0.0
Other	2.8

The geographical location of the speech and language therapy service determines, to a large extent, the capacity of the service to develop and respond appropriately to local needs. One of the effects of understaffing is that speech and language therapists in rural areas may have to travel long distances regularly to provide services in a number of locations.

28 therapists (19.3%) reported that they worked in four or more settings. This is related to the figure of 19 therapists (13.1%) who reported that they spent three or more hours per week in work-related travel

Other effects of understaffing in this context include speech and language therapists working alone, with reduced opportunities for team support and reduced budgets for inservice training, equipment and other necessary resources.

5.4 Client groups served

Chapter 3 gives details of the main client groups in need of speech and language therapy services. In practice, access to an appropriate service depends on the type of service required, and the location of the client in relation to the service. For an individual client, getting an appropriate service depends almost entirely on where he happens to live and not on his need for intervention.

In the IASLT questionnaire (1992), speech and language therapists were asked to identify the **main** client group to whom they provided a service. Replies were as follows:

TABLE 5.4: ***Main client groups***

Client Group	%age providing service to this group
general population	64
mental handicap	12.6
physical handicap	4
acquired neurological	3.7
ENT	2.2
cleft palate	.7
autism	.7
language disorder	4.4
other	4.4

While the above table illustrates the main client groups served at present, it does not indicate that some groups are well served at present relative to others. The distribution reflects the numbers of clients with particular disorders, as well as the overall development of services to these client groups.

The role of therapists in teaching/training of staff was discussed in general in 2.4 and in relation to specific client groups in chapter 3. The survey indicated that 62.4% of therapists were involved in staff education programmes either within their own organisation or in third level educational establishments.

5.5 Prioritization

The prioritization of specific client groups for assessment and intervention is an appropriate and necessary clinical management strategy.

However, prioritization policies are commonly used for service management, rather than clinical reasons. Speech and language therapists have reported that policies relating to prioritization are often developed and implemented in response to inadequate resources rather than to maximise benefit to clients, or to meet client needs.

Information on prioritization policies was sought in the IASLT (1992) survey. The returns indicated that the majority of therapists (64%) operated formal priorization policies.

These policies were initiated mainly by speech and language therapy departments and were subject to regular review.

The following criteria were used for prioritization.

59% by AGE
33% by CLIENT GROUP
66% by TYPE OF DISORDER
23% by OTHER

These were not exclusive categories.

Prioritization policies, in many cases, are effectively exclusion policies, if the group or groups given priority are so large as to require all available resources.

5.6 Exclusion

Access to the speech and language therapy service in both voluntary and statutory agencies may be restricted to certain groups as a service management strategy. Exclusion policies were reported to be in existence by 65% of respondents to the IASLT survey.
Exclusion criteria included:

a. Age - Many general clinics in community care excluded adults from therapy.

b. Client group - Exclusion policies operated against specific client groups e.g. mental handicap and dysphagia were also reported. This was linked by some to c below.

c. Lack of appropriate therapy specialism and/or lack of support services needed.

d. Catchment areas - defined catchment areas limited access to services for many voluntary agencies, while community care boundaries were also used by health boards.

Prioritization and exclusion policies for speech and language therapy services should be developed by speech and language therapists in consultation with management, should be based on sound clinical reasons, should be coordinated within and between Health Board areas and should be made explicit and available to referral sources and users of the service.

5.7 Caseload

Every speech and language therapist carries a caseload. This is the group of clients/patients for whose speech and language therapy she is directly responsible. The size of a caseload should reflect the needs of each client/patient and therefore the frequency, duration and type of intervention required. There are also other considerations in determining the optimum size of a caseload, such as the demands of teamwork, or the requirement for parent or staff training. These issues are discussed in

Chapter 6. In practice however, caseload size is more influenced by administrative, organisational and personnel considerations than the clinical demands of the therapy needed. The specification of a maximum number of clients on current caseload is highly unusual in Ireland, unlike the U.K. This puts great pressure on individual speech and language therapists to take 'just this one'. In The IASLT survey (1992) therapists were asked to specify a **number** of patients/clients on **current caseload**. The responses ranged from **5 to 1500**. The greatest number of replies (39 % of respondents) reported caseloads of more than 100. Replies are summarised in Table 5.5. It should be noted that the distribution of returns in this survey does **not** include information from those community care areas regarded within the profession as severely under-resourced and where therapists carry very large caseloads, e.g. parts of West and North Dublin.

TABLE 5.5: *Current Caseload*
(N=145)

Current Caseload	Number of Respondents	% of SLT's
0/no return	20	13.8
5 - 65	54	37.2
66 - 100	21	14.5
101 - 200	32	22.1
201 - 300	10	6.9
301 +	8	5.5

The mean caseload reported was 105.

It is entirely appropriate that the size of caseload should vary according to the makeup and demands of the population being served. However, the Irish Association of Speech and Language Therapists does not consider that a current caseload of over 100 clients is **ever** appropriate, and would hold that such caseloads make the delivery of a quality service impossible. Caseload recommendations will be discussed in further detail in the next chapter.

5.8 Waiting lists

Many people with communication disorders may not be referred to speech and language therapists because of lack of information about the relevance and benefits of the service and because of actual lack of service. When a referral is made, it is important that this first step in the process (see Figure 2) is followed quickly by others. In most service settings there is a waiting time between the referral and first contact with the speech and language therapist. This gap is caused by the need to process the referral, to identify a possible appointment time (sometimes in liaison with other professionals in the context of joint or coordinated assessments) and to give adequate notice of an appointment to the client. In practice, chronic understaffing leads to large waiting lists and a client in need of a speech and language therapy service may, in some cases, be waiting for over a year for an **assessment** of his needs.

A delay in the **assessment** of a communication disorder will almost inevitably lead to a worsening of the situation, and may lead to the development of secondary cognitive, educational, behavioural or social difficulties. It may also lead to difficulties which are more strongly established and therefore more difficult, lengthy and costly to treat. The economic implications of a failure to intervene appropriately could include special educational provision, educational failure, employment difficulties and future health and social welfare spending.

The IASLT survey (1992) indicated the following numbers on waiting list **for assessment.**

TABLE 5.6: ***Number on Waiting list for Assessment (N = 145)***

Number on W/L for Assessment	% of Replies
0/No reply	25.5
1 - 10	20.6
11 - 50	38.3
51 - 100	6.4
100+	9.2

The average time on the waiting list for assessment was also identified by therapists.

TABLE 5.7: ***Average Time on Waiting List for Assessment (N = 145)***

Time on W/L (in months)	% of Replies
0 / no reply	8.5
0 - 3	49.6
3 - 6	25.5
6 - 12	8.5
12 +	7.8

In some cases clients are seen relatively quickly for **assessment** and are then recorded as current caseload, **even if they are not being seen for therapy**. This creates the impression that waiting lists are shorter than they actually are.

The IASLT survey (1992) identified **the number on waiting list for therapy** (Table 5.8) and the average time spent on a waiting list for therapy (Table 5.9).

TABLE 5.8: ***Number on Waiting list for Therapy (N = 145)***

Number on W/L for Therapy	% of Replies
0/No reply	29.9
1 - 10	26.9
11 - 50	24.9
51 - 100	8.7
100+	9.6

One Speech and Language Therapist reported a waiting list of 496 for therapy

TABLE 5.9: ***Average Time on Waiting List for Therapy (N = 145)***

Time on W/L (in months)	% of Replies
0 / no reply	9.9
0 - 3	40.4
3 - 6	17.0
6 - 12	17.0
12 +	15.6

A waiting list for one speech and language therapist of over 50 clients already assessed and deemed in need of intervention is unacceptable. Almost half of the speech and language therapists who responded to this question reported an average time on a waiting list for therapy of **more than 3 months**, and almost a third reported an average time of more than 6 months. The clinical, therapeutic and economic implications of these figures are clear. There are also clear implications for the maintenance of professional standards in a setting where such pressures are on-going for the speech and language therapist.

5.9 Speech & Language Therapists in Private Practice

The demand for private therapy and the availability of therapists in private practice has been steadily increasing. Long waiting lists for children and a paucity of services for adults have contributed to this trend. Currently there are twenty speech & language therapists listed in the private practice register, twelve of these are in the Dublin area. All client groupings are represented in those seeking private therapy. A recent survey of private therapists carried out by SIG Private Practice indicated that all client groups are catered for, although the tendency is for therapists to specialise within nominated group(s) of disorders/ages, and some may not provide therapy for clients who normally require a multidisciplinary approach.

Clients are referred through medical and educational channels, and through self referral. The majority of clients would fall into one of the following groups.

1 Clients who are not prepared to wait on a waiting list for treatment;
2. Clients whose disorder will not receive attention in very busy clinics, as they are not a priority case;
3. Clients whose attendance at a private session is covered by special health insurance schemes or who prefer to pay for a service.

The majority of therapists in private practice can offer a fairly immediate assessment appointment, followed by immediate therapy sessions where necessary. This allows the private therapists to reduce a little of the pressure on the public waiting lists and to deal with the immediate anxieties of the client. Attendance at private therapy should not jeopardise the client's place on a prioritized waiting list in a public clinic if he is entitled to therapy under the Health Acts.

The therapist in private practice has the freedom to offer a variety of intervention strategies, including intensive therapy where indicated. She may be in a position to offer more flexible working hours, particularly in adult therapy.

There is very good liaison between therapists in private practice and therapists in public service. The Special Interest Group in Private Practice meets the specific needs of therapists in private practice through meetings and workshops.

Private practice provides a career opportunity for some therapists who would otherwise retire from practice e.g. as a result of family commitments, thus wasting a valuable resource in a small profession.

5.10 Continuing Professional Education

Speech and language therapy draws on the fields of medicine, psychology, neurology, linguistics, and others for the maintenance and development of its knowledge base. New information comes from theoretical models, academic and practicioner-based research and clinical practice. Speech and language therapists have an ethical and professional responsibility to undertake clinical practice which is well founded in accepted theory and based on best practice. Continuing professional education is, therefore, an imperative.
At present, continuing professional education is not mandatory and while some employers include a requirement to maintain professional standards by way of training in employment contracts, few provide adequate support for speech and language therapists to undertake continuing professional education.

Speech and language therapists were asked to describe supports provided by employers in the IASLT survey (1992).

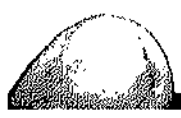


Table 5.10 indicates that while more than half of the speech and language therapists who responded believe that they are entitled to study leave, only 5.7% report that this entitlement is stated in their contracts.

Table 5.10: ***Study Leave***
(N = 145)

	% Yes	% No	% No response
Entitled to study leave	51.8	35.5	12.7
Entitlement stated in contract	5.7	74.5	19.8
Entitlement by custom and practice	61.0	14.2	24.8

Table 5.11: ***Supports for training provided in past year***
(N = 145)

	% yes
paid study leave:	7.1
unpaid study leave:	4.3
course fees:	5.0
travel expenses:	11.3
other study related expenses: (books etc.)	0

The information in Tables 5.10 and 5.11 suggests that while many therapists undertake and receive some support for continuing professional education, this is **not** a contractual entitlement - or obligation - for most. The danger in this situation is that such supports are subject to resources, and may be reduced or withdrawn at times of financial constraints. This was the experience of most speech and language therapists during the cutbacks of 1987/88 and following years.

Apart from the supports provided by employers, the availability of continuing professional educational opportunities is severely limited in range and frequency. In general, speech and language therapists make use of training opportunities which arise, rather than being able to plan a comprehensive and on-going strategy for professional development. Apart from postgraduate courses and research opportunities offered by third level institutions (see 1.4), short, occasional and in most cases uncertified training courses are organised by individual speech and language therapists and speech and language therapy departments, by Special Interest Groups, by the Irish Association of Speech and Language Therapists and the College of Speech and Language Therapists. Therapists also attend courses run by the Institute for Public Administration specifically for Health Service Personnel, courses run by allied professional bodies (the Psychological Society of Ireland, the Association of Occupational Therapists of Ireland). Speech and language therapists are involved in providing training to their own profession and

other practitioners in specific areas of need on an on-going basis eg. LAMH, Derbyshire Language Scheme.

There is a need for a comprehensive review of the need for and provision of continuing professional education for speech and language therapists. Requirements for registration and practice need to be established in order to maintain professional standards.

5.11 Support Structures and Services

Present levels of services are influences both directly and indirectly by the current structures and lack of support services. The following areas were identified as restricting the efficacy of service delivery.

a Limited opportunities to work in multidisciplinary/interdisciplinary teams. This may occur due to service setting or lack of personnel in associated professions. Therapists working in 3-4 settings or in those where their role is unofficial i.e. schools, find it difficult to develop team work skills.

b Accommodation — as was pointed out in 4.8 accommodation provided for therapists may restrict access to those with physical disabilities. Therapists also experience difficulties in obtaining suitable accommodation for education/training courses for parents/professionals and for student clinical training.

c Secretarial support — over one third (38.4%) of respondents to the IASLT questionnaire reported that clerical support was inadequate. This impact directly on time available for service delivery.

Summary

This chapter outlines current levels of services based primarily on national surveys undertaken in 1992. The outline presented illustrates the impact of the shortfall in staff on service delivery to clients.

CHAPTER SIX

PLANNING FOR THE FUTURE

6.1 Incidence and prevalence of communication disorders

6.2 Number of speech & language therapists needed

6.3 Staffing levels

6.4 Retention of therapists

6.5 Service prioritization

6.6 Support services

6.7 Service management

6.8 Research

6.9 On-going professional education

6.10 Standards — monitoring

6.11 Quality assurance mechanism

6.12 Registration

6 PLANNING FOR THE FUTURE

The main focus of this document is on the current levels of service provision to people with communication disorders. This chapter focuses on the future in an attempt to identify changes needed in order to provide an adequate equitable speech and language therapy service to those who require it.

6.1 Incidence and prevalence of communication disorders

Planning for service development requires detailed epidemiological information on speech and language disorders. The lack of adequate information on the size and needs of the population to be served has resulted in the uneven levels of service provision identified in the NESC (1987) report. Studies carried out in Ireland on the incidence and prevalence of communication disorders have been limited in both numbers studied and data interpretation and the estimates below are taken primarily from studies in the United Kingdom.

Enderby and Philipp (1986) estimated the numbers of people with communication disorders associated with underlying disease by a study of incidence and prevalence figures and populations. Their findings are summarized in table 6.1. Enderby (1988) cautions that these findings must be considered an approximation as "any difficulties in interpretation led to exclusion rather than inclusion".

These incidence and prevalence figures suggest huge under-reporting of disorders of communication in Ireland. There is a widespread concern among speech and language therapists working with a range of client groups and in a range of settings, that the needs of those to whom no service is provided within present resources is neither acknowledged nor addressed in planning future services.
The application of these figures to the Irish population can only be carried out with caution but they can provide a starting point for both service planning and research. There is an urgent need for research into the incidence and prevalence of communication disorders in Ireland. The identification of needs should be a priority of speech and language therapists in association with employers and service planners. Formal research projects identifying the needs of specific client groups are needed along with screenings of general populations. Information from such research needs to be collated and made available to service planners.

6.2 Number of speech and language therapists needed

The figures provided from the studies outlined above would indicate that approximately 4000 people in a population of 100,000 will present with a communication disorder. Enderby (1988) suggests that this requires a staffing level of 23.37 speech and language clinicians per 100,000 population and concludes that "without this level of staffing service provision is spread thinly and the allocation is not usually done on a

rational basis". The development of the service to date in Ireland has resulted in staffing levels much below this figure as indicated in 5.2. The need for a major increase in staffing levels has been stressed throughout this document. The figures as presented indicate a need for 818 therapists compared to present level 187. The shortfall of 631 therapists is unlikely to be remedied in the near future because of the limited funding available to the health services in general and also because of the shortage of qualified speech and language therapists. While it is hoped that this document will sharpen political awareness of the needs of people with communication disorders and that increased resources will result in major staffing increases, it is also necessary to examine how service providers and the profession can best utilize current limited resources to improve the services available.

6.3 Staffing levels

Recommended caseloads for speech and language therapists are dependent on many factors other than basic client group and the IASLT working party recommend caseloads as shown on table 6.2 must be viewed with these in mind. This table shows the recommended notional caseloads from the Hughes and Stuffins survey (1984) and the suggested IASLT maximum current caseload. The issues to the right of the table are those which were felt to be influencing current service provision to these client groups thus necessitating revision of the 1984 figures. The maximum case load must be viewed in terms of both the model of care offered and the other services available to the client.

6.4 Retention of therapists

The previous sections have outlined the need for a major increase in staffing levels but the issue of keeping therapists in the profession must also be addressed. Some of the reasons for the loss of therapists to the profession have been outlined in 1.2 and it is recommended that a review of contracts and work practices be undertaken in order to retain staff.

Efforts to retain staff should begin as soon as a graduate commences work and early contracts should reflect the need for the beginning therapist to have adequate support and supervision along with broad based clinical experience. On going staff education and training should be provided in order to allow staff to develop expertise and specialist skills (see 6.9). The retention of therapists in the profession is also dependent on the career and pay structure and the current grading structure has proved limiting in this area (appendix 2). Recommendations on changes in this area will not be discussed here as these are primarily a matter for negotiation between unions and central planners but the need for change to a structure that will recognize specialist skills must be stressed if the loss of highly qualified therapists is to be halted. Creative flexible work contracts may also help to keep therapists in the profession e.g. flexible working hours, term time contracts etc. may facilitate therapists with family responsibilities. Rotational posts may be used to encourage development of specialist skills.

Table 6.1: ***Estimates for the size of the UK speech and language handicapped populations associated with certain medical problems*** ***1985 (Listed in order of decreasing prevalence of the disorder.)**

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Disorder	Incidence of disorder per 100,000 population	Prevalence of disorder per 100,000 population	Percent with disorder causing speech or language problem	Number of speech /lang handicapped per 100,000 population	Number of severely speech/ lang handicapped per 100,000 population	Number with moderate speech/lang handicap per 100,000 population
Mental handicap (all ages)	NK	2,500.0	55.0	1375.0	800.0	575.0
Stammering	3495.0	1,070.0	100.0	1070.0	70.0	1000.0
Pre-school age speech & lang**	NK	691.2	100.0	691.2	230.4	460.8
School age speech & lang**	NK	400.0	100.0	400.0	200.0	200.0
CVA	200.0	500.0	30.0	150.0	70.0	80.0
Deafness	1.6	200.0	60.0	120.0	45.0	75.0
Cerebral Palsy***	2.0	175.0	60.0	105.0	20.0	85.0
Cleft Palate***	2.0	NK (>142.0)	40.0	57.0	19.0	38.0
Parkinson's Disease	20.0	125.0	55.0	69.0	23.0	46.0
Multiple Sclerosis	3.0	60.0	55.0	33.0	10.0	23.0
Dysphonia	28.0	28.0	100.0	28.0	10.0	18.0
Muscular Dystrophy	1.2	20.0	25.0	5.0	2.0	3.0
Motor Neurone Disease	1.6	6.0	57.5	3.5	1.2	2.3
Myasthenia Gravis	3.0	6.0	25.0	1.5	0.5	1.0
Huntington's Chorea	0.4	5.0	60.0	3.0	1.0	2.0
Laryngectomy	0.9	3.0	100.0	3.0	2.0	1.0
Friedreich's Ataxia	0.4	2.0	60.0	1.2	0.6	0.6
Head Injury	286.0	NK (800)	20.0	NK (160)	NK (60)	NK (100)

* Many of the figures in this table are estimated from references cited in the text. They should be used as a guide rather than a definitive statement.

** The incidence and prevalence estimates are derived from the number of pre-school children per 100,000 general population

*** Based on the numbers per 100,000 new born population.

NK not known.

Table 6.2: Client Groups

CLIENT GROUP	HUGHES AND STUFFINS	IASLT	ISSUES
General Population-preschool:0-6 yrs	40-60	30-40	
General Population-school-age:6-16 yrs inc fluency	40-60	40-50	Laison -staff/parent/other Personnel: parent/staff training: Travel/domiciliary
Severe Speech and Language Disorder (child)	10-14	8-10	Emerging needs of older children Liaison with school Travel
Preschool Unit	10-14	8-10	Intensive
School Age (class)	10-14	6-8	"
Autism	8-14	8-10	"
Physical Disability	20-30	0-6: 6+ 20: 25-30	Travel Liaison with other personnel
Emotional Disturbance	25-49	20: "	Home based intervention
Mental Handicap	25-49	20: "	Staff/parent training Home-based therapy
Visual Impairments	----	20. NR	
Hearing Impairment	20-29	25-30 NR	
ADULTS			
Mental Handicap	50-74	50 - 60	Environment Vocational Training Staff training
Physical Handicap	20-39	50 - 60	Alternative and Augmentative Communication Vocational programmes
Neurological (CVA, Head injury, tumour) Setting general Rehab Daycare Acute	--- 20-29 10-19 --- ---	10-19 10-19 8-15 20-30 10-20	Quality of life Appropriate settings
Progressive Disorders	---	10-19	Changing needs AAC: Domiciliary
Geriatric	20-29	30-40	Changing needs e.g. dysphagia
Voice	10-19	10-30	Lower figure for laryngectomy
Fluency	20-29	30-35	
Dysphagia	****	NR	

NR = NO recommendation made

6.5 Service prioritization

Prioritization of caseloads is recognized as part of clinical organisation but this must occur based on a range of criteria. Blanket exclusion (see 5.6) which discriminates against the individual with a communication disorder because of client group, age or educational placement cannot be justified clinically. Criteria in use in prioritization policies will be dependent to some extent on the type of setting - eg. hospital, community clinic, mental handicap setting etc, and are also dependent on the number of client groups served.

Clinical criteria could include:

- optimum timing of intervention;
- communication disorder in relation to environment demands;
- client or family anxiety;
- expected outcome;
- availability of resources needed - skilled staff, equipment etc.

Organizational criteria could include:

- age;
- type of disorder;
- health entitlements etc.

It is recommended that prioritization policies be formulated clearly by speech and language therapists and that these policies be reviewed regularly in the light of changes in consumer demands, resource availability etc. The aim of any prioritization policy must be to make the best use of the available resources in the service provision to those with communication disorders.

6.6 Support services

The previous chapters have outlined a bleak picture of current staffing levels and the resultant shortfalls in service delivery. While it is hoped that increases in resources would enable gaps to be bridged in the future, the present lack of qualified therapists has resulted in the examination of possible support services which would facilitate service delivery, increasing time available for clients.

A . Speech & Language Therapy Assistants

Speech and language therapy assistants have been employed in the United Kingdom since 1988. It was originally felt that these could have a role in future service delivery in Ireland but a review of current literature and research findings would indicate that this cannot be recommended at present as:

- present staffing levels are below the levels acceptable to make assistants viable (Turner,1992);
- the use of assistants has been shown to be less cost effective than estimated (Van der Gaag,1992);

— the knowledge and skill basis needed for the role of assistant have not yet been sufficiently well defined to allow training courses to be organized.

The IASLT cannot recommend the employment of assistants at present for the above reasons.

Surveys carried out for this document indicated that over one third of therapists (38%) had inadequate clerical/administrative supports. Studies have indicated that therapists spend between 20% and 26% of their time in routine administrative tasks which could be delegated if adequate administrative secretarial support was available (Enderby & Davies,1989; Smith,1992). The increase in administrative support could result in the freeing up of therapists time which would impact directly on service delivery.

B Multidisciplinary Teams

The earlier sections of this document have identified the needs for multi and interdisciplinary team supports needed to provide adequate services to client with communication disorders. Improvements in health and education services in many areas may result in reduced pressure on the speech and language therapy services.

6.7 Service management

The role of the speech and language therapist in service planning and development has been restricted to date. The restrictions have been imposed by factors outside the profession as discussed in chapter 4 as well as the unclear role of the therapist in organisational management. The operational difficulties of the existing organizational structures within the health services have been identified by many government and agency reports over the years (NESC 1987; Foley, 1989; Kennedy, 1990) and will not be discussed in detail here. The difficulties encountered by therapists in planning and delivering a service to clients have been detailed in chapters 4 and 5 and the resultant patchy, inequitable service outlined. It is hoped that proposed changes within health services structures will proceed and will result in a more integrated and comprehensive service for all. The IASLT working party response to the proposed re-organization of the health services in the Dublin region stressed the need for speech and language therapy representation at all levels of management ie. regional, area and district to ensure that a comprehensive and integrated service is provided to those with communication handicaps. The role of the speech and language therapist at management level includes the identification and assessment of needs and the planning of services to meet these needs.

The identification and assessment of need may be carried out by:

— Incidence and prevalence studies of a disorder in the given population, e.g. incidence of language disorder, stuttering.

Some studies have been done in this area eg. language disorder in Clare, stuttering in Gaeltacht areas (reported by Leahy, 1986);

— Client group-based - Information on specific client groups and the incidence in the population eg. clients with mental handicap, clients with cleft palate. Clinical studies would indicate higher incidence of some groups in certain geographical areas eg. cleft palate, spina bifida, Down's syndrome along the western seaboard;

— Area-based assessment utilizing epidemiological studies.

While all of the above have been used in many areas for service planning the results have had little impact outside the immediate area because of a lack of central planning or information sharing structures. Speech and language therapy input into regional planning has been limited because of the lack of a formal role on management teams. It is vital that this role be recognized in order to develop services that meet local needs. The information generated by regional studies should also be available to central planning to facilitate relevant service planning and resource allocation.

6.8 Research

The need for research in all aspects of communication disorders has been identified in previous chapters of this document. Gaps in knowledge of incidence prevalence, treatment efficacy etc. have been outlined. The previous section has pointed out the need for information in order to plan and service to meet the needs of people with communication disorders.

Some of this information should be readily available from speech and language therapy administration files but as was pointed out in 5.7, a lack of agreement on basic terminology hampered this area of the research undertaken for this document.

The questionnaire returns (1992) highlighted a fundamental difficulty in addressing the issues of caseload and waiting lists, and in comparing these across client groups, clinical settings or employer. This is the difficulty of definition. It is clear from these returns that speech and language therapists, in common with health boards, the Department of Health, and other health professionals, use the term **caseload** to denote clients and patients in vastly different relationships to the therapist.

The lack of definition of caseload has resulted in information that is of limited value in identifying needs, service planning, and service evaluation. It may also result in the masking of client needs as it was felt that the review category was been used as form of waiting list.

The I.A.S.L.T. proposes the following working definition for the term **caseload:**

The current caseload is the number of clients/patients who are currently attending therapy, either on a regular or review basis.

In this definition, it is assumed that **review** is used for therapeutic rather than administrative reasons. It is further recommended that the **caseload** should specify, in percentage terms, those clients/patients who need further specialist, group or intensive input.

The I.A.S.L.T proposes the following working definition for the term **waiting list:**
The Waiting List is made up of two distinct groups:

1. **those referred but unseen (i.e. not assessed);**
2. **those referred, assessed and awaiting therapy.**

This document recommends that a rationalisation of terms used to describe and record the needs of and services provided to clients be urgently undertaken. Recording systems summarizing therapy/treatment programmes also need to be rationalized in order to accumulate useful information on efficacy.

The Quirk Report (1972) stressed the importance of employers facilitating therapists at all levels to undertake research in order to estimate needs and evaluate therapy. This need is as great today as it was twenty years ago and the reasons given by employers for not facilitating research today are similar to those given twenty years ago "staff shortages and the consequent burden of treatment cases mean that speech therapists can very seldom be released from even a proportion of their clinical duties to enable them to undertake part-time research" (Quirk, 1972).

This document recommends that the brief of the speech and language therapist at all levels of service should include research and that this research be facilitated by employers through the provision of adequate support structures. It is not envisioned that this research brief be added to the already overburdened therapists load but that standardized collection of statistics should replace some of the current inefficient methods of data collection. Therapy waiting lists, caseload figures and treatment studies can yield useful information to service planners if terminology difficulties can be overcome. Therapists, employers and central planners should seek to identify what data is required, define terminology and design manual and computer methods to facilitate collection. Research information must be shared between service providers and central planners if it is to be used to develop an equitable service.

6.9. On-going professional education and development

The previous sections have outlined possible changes in service management and delivery. These changes along with the continued growth of professional knowledge necessitates the organisation of systems to support on-going professional development at both inservice and academic levels. The limitations of current training/education provisions have been identified in 1.4 and 5.10. Continuing education

should be seen as an integral part of the therapist's role in order to ensure that services to clients are underpinned by a sound knowledge base. Therapists have a responsibility for ensuring that they work within their range of competency and therefore must actively participate in identifying their own development requirements. The speech and language therapist's professional development can be facilitated by courses, seminars, study days, case reviews and presentations, literature review and discussion, regular appraisal with objective setting, shared case management and observational opportunities.

Employers must support therapists in their continuing education if adequate services are to be developed. Education and training programmes need to be developed at two levels: a) academic and b) inservice education/training.

A. Academic: The range of postgraduate educational opportunities needs to broaden and it is hoped that options such as a taught masters course will be viable in the future. The number in the profession to date and the lack of supports for therapists to pursue further study has mitigated against this option in the past. The working party would also recommend that distance education models or systems of credit points from professional courses should be explored in order to provide more academic opportunities. It is also recommended that those undertaking research in therapy efficacy should be adequately funded by central planning in order to fill some of the gaps in knowledge identified in this document.

B. Inservice education/training: Therapists also require opportunities to increase knowledge and develop skills in areas related directly to their work both client related and administrative. Inservice education policies should be developed by employers in association with speech and language therapists in order to ensure that local needs are met.

It is hoped that programmes in both areas above would in the future be validated by an education board in order to ensure that standards are set and monitored.

6.10 Standards

This document has identified many areas where therapists feel that the standard of services to people with communication disorders are threatened, eg. limited opportunity to develop knowledge/skills, inadequate record keeping, pressures of large caseloads, long waiting list etc. The awareness of the threat to standards has resulted in low morale, high stress levels and loss of therapists to the profession. Current systems of service management not only stresses the therapist but may also mask the needs of individual clients and client groups. Standards of service as outlined in Communicating Quality (1991) need to be related to local settings and resources and acceptable levels of performance and service delivery set. Standards are needed in the areas of waiting list and caseload management, assessment and intervention procedures, therapy

outcomes and general and specific preventative work. Only when standards are agreed can shortfalls be identified accurately and plans for appropriate development of services be put in place.

6.11 Quality assurance mechanism

Standards can only be maintained by the use of monitoring systems. Current systems focus on caseload figures and through input rather than evaluating quality of service in relation to client needs. Speech and language therapists need to be supported in developing and using service and clinical audit systems so that the quality of their work can be recognised but also in order to highlight shortfalls and facilitate planned service development. A pilot study in clinical audit procedures for speech and language therapy services is currently underway in the U.K. (Van der Gaag,1992) and this may identify the most appropriate methods for undertaking such audits. Transfer of such studies to Ireland would require initial resources from central planning for development work and open, effective communication systems at both local and national levels.

6.12 Registration

Statutory registration of speech and language therapy and other health/social professions have been under discussion with the Department of Health for the past 13 years but difficulties in obtaining agreement on the necessary structures have halted the process on many occasions. The issue has been compounded for speech and language therapists because of the small numbers involved and the financial demands on a small profession of maintaining a registration board. Registration is perceived as necessary in order to:

— protect members of the public by providing assurance of the competence and quality of those providing a service;

— provide employers with an effective mechanism for ensuring that those employed to work in a profession are properly qualified to do so;

— allow the professional group to protect its own good name and standing by ensuring that members act in the best interest of their clients.

The lack of registration has resulted in unqualified people being employed, in particular in the voluntary sector. It is envisioned that the demand of EC directive 89/48 and the resultant freedom of movement within the European Community may speed up the process of voluntary registration but in the interim period it is recommended that the IASLT investigate non-statutory registration in order to provide some degree of protection for service providers and users.

Summary

This chapter outlines the need for increases in resources to the speech and language therapy service in order to improve staffing levels and service delivery. The need for professional development in management, research and setting and monitoring standards is outlined.

CHAPTER SEVEN

Recommendations

7 RECOMMENDATIONS

This chapter presents a range of recommendations addressed to those who are involved in policy development, service planning and service delivery to people with communication disorders. The recommendations are addressed to those perceived to be in the best position to initiate and support action but it must be stressed that growth and development of the service can only proceed if all involved work together. The recommendations are supported by information in the text and relevant references are provided.

7.1. Action by Department of Health

1. It is recommended that the Department as the central planning organisation promote epidemiological research in order to identify those requiring a service.
   2.7; 3.1-13.

2. The Department should recognise the current serious shortfall in therapists employed and plan for significant increases in the immediate future.
   3.1-13; 4; 5.1-9; 6.1-3.

3. Preventive education and general information programmes on communication disorders should be supported by the Department through the Health Promotion Unit. Such programmes to be aimed towards influencing attitudes of the public to people with communication disorders as well as preventing disorders with at risk groups.
   2.5; 3.2; 3.10.

4. The department should re-examine the feasibility of statutory registration in order to protect both service users and providers.
   6.10-12.

5. The Departments of Health and Education should liaise to ensure that services to children in schools are developed to meet the needs of those requiring speech and language therapy in order to benefit from the educational system.
   3.1-6; 4.4-5.

6. The Department should facilitate the representation of therapists at planning and management level by:
   a) Promoting the importance of this role with employers and utilizing the IASLT as consultants in central planning.

   b) Facilitating the development of an appropriate grading structure to formally recognise this role. New grading structures should reflect specialist skills of therapists with specific client groups in order to ensure that planning and service delivery is co-ordinated both between and within agencies.
   1.2; 4.2; 4.8-9; 6.4; 6.7.

7. It is recommended that the Department support research in areas of needs identification, service delivery and quality assurance in order to facilitate planning and resource allocation. This support should include information systems development and accessing information as well as funding to suitable research projects.
2.7; 3.1-13; 6.5; 6.10-11; 8.

8. The Department should facilitate agreements between voluntary and statutory agencies with regard to service provision to all client groups and base resource allocation on such agreements.
4.1-7; 5.5-6.

9. The Department should actively support the on-going professional education of therapists by encouraging employers to provide support for such programmes and by the recognition of post-graduate qualifications in remuneration.
1.7; 2.8; 5.10; 6.4; 6.9.

7.2 Action by Employers - Statutory and Voluntary

1. Statutory and voluntary agencies should formally agree responsibility for service to client groups in common areas. The changing demands on therapists due to the trend towards community care should be acknowledged and resources allocated to local clinics or peripatetic teams to develop services to specific client groups e.g. people with mental handicap, adults with neurological disorders.
3.1-13; 4.2; 4.7-8; 6.10.

2. Employers should encourage the involvement of speech and language therapists at management level in resource allocation and service planning in order to ensure that the needs of people with communication disorders are represented.
4.1; 4.7-8; 6.7; 6.10 11.

3. Research should be facilitated by employers by the provision of necessary resources and a recognition of its impact on caseload levels.
2.7; 5.10; 6.8; 6.10-11.

4 Employers need to facilitate the involvement of therapists in prevention and education programmes by their inclusion in job descriptions and the provision of necessary resources.
2.5; 3.2.

5. Adequate support structures, both personnel and technological, should be provided for therapists in order to maximize time available for client-related work.
2.6; 5.11; 6.6; 6.8.

6. Employers should actively support therapists in developing knowledge and skills through on-going professional training.
2.8; 5.10; 6.4; 6.9-10.

7.3 Action by Speech and Language Therapists

1. It is recommended that therapists work with the IASLT to define terminology and develop recoding systems which will provide an accurate picture of current services and waiting lists.
2.11; 6.5; 6.10.

2. Prioritization and exclusion policies for speech and language therapy services should be developed by speech and language therapists in consultation with management, should be based on sound clinical reasons, should be co-ordinated within and between Health Board areas, and should be made explicit and available to referral sources and users of the services.
4.2; 4.7; 4.8; 6.5; 6.10.

3. Speech and language therapists need to undertake research in both client needs, therapy outcomes and service management if allocation of resources is to be planned and an appropriate service delivered in future.
Areas identified for research in this document include:
a) Standardization of assessments both in English and Irish on Irish population.
b) Development of screening procedures and preventative programmes for at risk groups.
c) Efficacy studies on management and intervention strategies with specific client groups.
d) Information systems suitable for data base development for clients with communication disorders.
e) Development of quality assurance mechanisms.
Results of research projects should be made available to the profession and planners via publications and a central resource centre.
2.7; 3.1-13; 6.8; 6.10-11

4. Speech and language therapists in association with the IASLT and the Health Promotion Unit should work to increase knowledge of communication disorders and their impact on people by the provision of explanatory literature and videos.
2.5.

5. Speech and language therapists should undertake regular on going educational programmes to update and expand knowledge and skills.
2.8; 5.10; 6.9

CHAPTER EIGHT

PROFESSIONAL SUPPORT SYSTEMS

8.1 The Irish Association of Speech and Language Therapists

8.2 The College of Speech and Language Therapists

8.3 The Irish Association of Principal Speech and Language Therapists

8.4 IMPACT

8.5 Comite Permanent de Lialson des Orthophoniste-Logopedes de la C.E.

8.6 International Association of Logopedics and Phoniatrics

8.7 Special Interest Group of Speech and Language Therapists in Mental Handicap

8.8 Special Interest Group of Speech and Language Therapists in Private Practice

8.9 Augmentative and Alternative Communication Society of Ireland

8 PROFESSIONAL SUPPORT SYSTEMS

8.1 Irish Association of Speech and Language Therapists

The IASLT is the recognised professional association of speech and language therapists in Ireland working at a national and international level on professional issues. The aims of the profession include:

- To develop and maintain professional standards.
- To advance the education of speech and language therapists at all levels
- To co-ordinate and disseminate information on the speech and language therapy services.
- To promote the exchange of professional information between therapists via publications, study days, seminars.
- To represent Irish speech and language therapists at international level via membership of appropriate organizations.

The IASLT is affiliated to the IALP and CPLOL (see below).
Membership of IASLT is open to all professionally qualified speech and language therapists working in Ireland.

Contact Address: IASLT,
PO Box 1344,
Dublin 4.

8.2 The College of Speech and Language Therapists

The College of Speech and Language Therapists is the professional body governing the speech and language therapy profession in the United Kingdom. The college is committed to ensuring high standards are available to all, and to this end provide:

- Professional standards for therapists as specified in *Communicating Quality* (1991);
- Professional consultancy division to inform and advise service providers on issues such as service management;
- Professional supports for speech and language therapists via specialist advisers, resource centres etc;
- Continuing education opportunities with certified postgraduate programmes;
- Journals and publications.

Members in the Irish region work with therapists in Northern Ireland to facilitate professional supports and information exchange opportunities.

Contact Address: 7 Bath Place,
Rivington Street,
London EC2A 3DR.

8.3 The Irish Association of Principal Speech & Language Therapists

This association was established to:

- Promote and develop the speech and language therapy service
- Develop the role of principal speech and language therapists as competent managers within the existing structures of the Health Services.
- Identify speech and language therapy needs within the community
- Liaise with statutory bodies and management as appropriate.

Members of the association are qualified speech and language therapists who have been appointed Principal or Acting Principal. There is close liaison between the Association and the I.A.S.L.T.
Contact address: may be obtained from Secretary, IASLT.

8.4 IMPACT

The majority of speech and language therapists who are union members are members of IMPACT — the public sector trade union. The union provides advice and support to therapists in employment-related issues and enters into negotiations on their behalf.

Contact address: IMPACT, 9 Gardiner Place, Dublin 1.

8.5 Comite Permanent de Liaison des Orthophoniste-Logopedes de la C.E. (CPLOL)

C.P.L.O.L. is the permanent liaison committee of E.C. Speech and Language Therapists and Logopedists. The committee aims to ensure that the profession throughout the European Community is aware of new developments and it fosters active involvement in these through working parties and the organisation of a European congress. Irish representatives are currently involved in the following projects:

- Scientific Committee to organise the second European Congress in 1994;
- Professional Profile;
- European Code of Ethics;
- Terminology Committee to establish a European Data Bank.

8.6 International Association of Logopedics and Phoniatrics (IALP)

The aims of the I.A.L.P. are to promote and develop standards of rehabilitation and preventative work, research and education in logopedics and phoniatrics. The IALP was founded in 1924 as an international multiprofessional group for those involved with disorders of communication. The IALP facilitates information sharing between its members world wide via its journal Folia Phoniatrica and triennial congresses.

It has two forms of membership, individual membership and membership for affiliated societies. Individual members receive 6 issues of Folia Phoniatrica annually, they have reduced fees for Congresses, are eligible to vote for Board members and topics for Main Reports at the Congresses. Each affiliated society is entitled to delegates - proportionate to the number of members in the society. These delegates have similar voting rights to individual members and represent their society at the Delegates Meeting held during the Congress. At present there are approximately 544 individual members and 56 affiliated societies representing 37 countries.

Contact Address: Sr Marie de Montfort, President IALP,
School of Clinical Speech & Language Studies,
Trinity College,
Dublin.

8.7 Special Interest Group of Speech and Language Therapists in Mental Handicap

The S.I.G. in Mental Handicap was established in 1981 in response to an increasing realisation of the specialised needs of people with an intellectual disability. The S.I.G. facilitates speech and language therapists working in the field who have common experiences and difficulties, in offering support and providing a forum for discussion and resolution of problems. The group organizes study days and workshops to provide opportunities for therapists to develop specialist knowledge and skills.

Contact Address: may be obtained from Secretary IASLT.

8.8 Special Interest Group Speech and Language Therapists in Private Practice

Speech and language therapists with a range of specialisations are working in private practice in the community. The group provide professional support for therapists in private practice and allow information exchange between therapists in private practice and other therapists. The group compile and hold a register of therapists involved in private practice which may be consulted by referral sources.

Contact Address: may be obtained from Secretary IASLT.

8.9 Augmentative and Alternative Communication Society of Ireland

This is an organization for professionally or technically qualified persons working directly or indirectly in the field of augmentative and alternative communication. It aims to encourage the exchange of information among professional groups involved in the development and implementation of aided and unaided communication systems. It also promotes the development and appropriate use of technology to facilitate the communication and independence of people with disabilities.

Contact Address: may be obtained from Secretary IASLT.

Appendix 1

Course Content:

JUNIOR FRESHMEN		SENIOR FRESHMEN		JUNIOR SOPHISTERS		SENIOR SOPHISTER	
Audiology & Auditory Per. Function	52	Disorders of Aud. Perception	6	Disorders of Comm unication in Children and Adults	203	Disorders of Comm-unication in Children and Adults	96
Reading	14	Language . Disability	50	Associated Pathological Dis	19	Associated Pathological Dis	6
Introd to Hum. Com.Disorders	5	Fluency & Dis. of Fluency	20	Human Communication Project		Human Communication Project	
Anatomy	24	Neuroanatomy &	60				
Physiology	12	Anatomy		Applications of Research Design & Method	20	Psychology Language & Thought	10
Lang. Acquis	5	Physiology	34				
Introd. to Psychology	30	Clinical Skills	6	Psychology Attention & Memory	10	Counselling (incl Family therapy)	30
Normal develop (incl language)	30	Research Methodology & Design	30	Lifespan Devel.	5	In-depth Case Study	
Child Dev (B.Ed)	20	Psychology of Individual Differences (Assess. & Intervention)	20	Neuropsychology	8		
Linguistics				Linguistics			
Phonetics	46			Dis. Analysis	18		
Language Acq	46			Sociolinguistics	18		
Introd. to Lang Studies CLCS	46	Child Psychiatry	6	Advanced clinical linguistics	10		
Paediatrics	4	Linguistics		Neurology			
Instrumental Phonetics	6	Syntax/morphology	18	Child & Adult	30		
		Phonology	27				
		Clinical Linguistics	10	Psychiatry adult	10		
Total	340		287		351		142
Clinical Obs and Practicals Audiology	25	Clinical Obs & Practice	210	Clinical Obs & Practice	240	Clinical Obs & Practice	210
		Professional Skills	10	Specialist clinics	10	Specialist clinics	10
Normal Devel Studies	55	Assessment Tech.	8				
TOTAL	420		515		601		362

Appendix 2

Grading Structures

Present grading structure within the Profession.

Recommended grading structure agreed at the Working Party set up on the 19th January, 1979. Taking part were representatives of the L.G.P.S.U., the Department of Health and the Local Government Staff Negotiations Board.

The Working Party had recognised that the lack of a grading structure was unsatisfactory.

It recommended that there be 4 grades applicable to both Health Boards and Voluntary Hospitals.

	Health Boards	**Voluntary Hospitals**
Principal Grade I	A speech therapist in charge of the speech therapy services in a Community Care Area in which a total of at least 6 speech therapists are employed.	A speech therapist in charge of speech therapy services in a hospital in which a total of at least 6 speech therapists are employed.
Principal Grade II	A speech therapist in charge of the speech therapy services in a community care area in which a total of at least 3 speech therapists are employed.	A speech therapist in charge of speech therapy services in a hospital in which a total of at least 3 speech therapists are employed.
Senior Grade	A speech therapist working single-handed in charge of a clinic (ie. a centre) or a speech therapist in charge of a clinic or department where at least 2 speech therapists are employed.	A speech therapist working single-handed in charge of a clinic (ie. a centre) or a speech therapist in charge of a department, or a sub-division of a department which is a distinct entity, in which at least 2 speech therapists are employed.
Basic Grade	All other speech therapists.	All other speech therapists.

The effect of the above recommendation is set out in the following table.

Numbers employed	Basic	Senior	Principal II	Principal I
1	-	1	-	-
2	1	1	-	-
3-4	2-3	-	1	-
5	3	1	1	-
6	4	1	-	1
7-8	4-5	2	-	1

A requirement of at least three years satisfactory post-qualification experience would apply to all senior appointments and of at least five years satisfactory post-qualification experience to all principal appointments.

IRISH ASSOCIATION OF SPEECH AND LANGUAGE THERAPISTS

POLICY REVIEW and SALARY QUESTIONNAIRE

1. **Name** _____

2. **Qualification** _____ 3. **Where obtained** _____

4. Year of Qualification _____ 5. Number of years working _____

Employment

6. Are you working as a Speech and Language Therapist ? YES _____ NO _____

7. If yes, do you work full-time _____ part-time _____

If NO, please complete questions 13 and 14

8. If part-time, how many sessions per week

1. 1-4 _____ 5- 9 _____ 3. 10+ _____

9. Present Grade _____ 10. Number of years at this grade: _____

11. Point on salary scale _____

12. Present Employer Please tick as many boxes as necessary:

EHB	_____	1			
NEHB	_____	2	Voluntary Hospital	_____	9
SEHB	_____	3			
SHB	_____	4	Other Hospital	_____	10
MHB	_____	5			
WHB	_____	6	Voluntary Agency	_____	11
NWHB	_____	7			
MWHB	_____	8	Self	_____	12

If you are working as a Speech and Language Therapist (SLT), please go to question 15.

13. If you are **not** currently working as a SLT, please specify primary reason

Family reasons	_____	1
change of career	_____	2
further speech therapy study	_____	3
poor pay	_____	4
no appropriate speech therapy job available	_____	5
other (specify)	_____	6

14. If you are not currently working as a SLT, do you intend working in this area in the future

YES _____ NO _____ DON'T KNOW _____

The remainder of the questionnaire is not relevant to those not currently working as SLTs. Thank you for completing these questions. Please return your completed form.

Further Qualifications and Training.

15. Have you aquired, or are you working towards, any formal qualification related to your work,

YES _____ NO _____

Specify Qualification(s) (do not use abbreviations)	Awarded by

Setting

16. Please tick **one** category of base clinic and as many categories as you need for other settings:

		MAIN/BASE	OTHER	
Community Care Health Centre/Clinic				1
Child and Family Centre				2
Hospital :	General			3
	Rehabilitation Centre/Unit			4
	Long stay/special			5
	developmental/assessment clinic			6
	Private			7
Education:	Preschool/Nursery			8
	primary school			9
	special national school			10
Day Centre:	Developmental Day Centre			11
	Adult Training Centre/Workshop			12
University Clinic				13
Home/ Private Office				14
Client's home				15
Other (specify)				16

17. Specify work-related travel time per week 1. 0 - 1 hr. _____ 2. 1 - 3 hrs _____ 3. 3+ hrs _____

18. Is this time included in your work time YES _____ NO _____

19. Do you get travel expenses? YES _____ NO _____

Caseload management

20. Number on current caseload: _____

21. Number on waiting list for therapy _____

22. Number on waiting list for assessment_____

23. Average time on waiting list for assessment

Time in months	0 - 3	3 - 6	6 - 12	12 +

24. Average time on waiting list for therapy

Time in months	0 - 3	3 - 6	6 - 12	12 +

Current Caseload:

25. Age groupings: Please identify the percentage of your caseload in each category:

age	0 - 4	4 - 6	6 - 13	13 - 16	adult
% caseload					

26. Type of disorder, by **primary presenting disorder**

Disorder	% Caseload
language - developmental	
language -acquired	
artic/phonology - developmental	
artic/phonology acquired	
fluency	
voice	
eating/swallowing	

27. Identify the main client group to which you provide a service. Tick only **one** category.

Client Group		
general population		1
mental handicap		2
physical handicap		3
acquired neurological		4
ENT		5
cleft palate		6
autism		7
language disorder		8
other		9

Prioritisation and Exclusion Criteria

28. Has your clinic a formal policy for prioritisation? YES _____ NO _____

29.If yes: Who initiated this policy?

SLT Dept	SLT + Management	Management only

30.Is this policy reviewed? YES _____ NO _____

31. Does the policy apply to all services _____ or to SLT alone _____

32. How is priority established (tick as many as necessary)

by age _____ 1 by type of disorder _____ 3

by client group _____ 2 by other (specify) _____ 4

33.Are particular groups of clients/patients excluded from therapy ? YES _____ NO _____

34.If YES, identify the basis for exclusion: Tick as many as necessary.

age	_____	1
client group	_____	2
type of disorder	_____	3
severity of disorder	_____	4
associated disorders	_____	5
additional services/ support needed	_____	6
transport needed	_____	7
catchment area	_____	8
lack of appropriate therapy specialism	_____	9
other (specify)	_____	10

Clinical management

35. Identify your main referral sources

AMO	_____	1
G.P.	_____	2
S.M.O.	_____	3
Medical Specialist	_____	4
Psychologist	_____	5
Teacher	_____	6
PHN	_____	7
Parent/ Client	_____	8
Other therapist	_____	9
Other (please specify)	_____	10

Are clients/patients mainly referred

36. Directly to you _____ OR 37._____ To your team _____

Study leave

38.Are you entitled to annual study leave YES _____ NO _____

39.Is this stated in your contract YES _____ NO _____

40.Is it by custom and practice YES _____ NO _____

41.In the past year, have you been provided with any of the following by your employer (please tick)

1.Paid study leave _____ 2.Unpaid study leave _____ 3.Course fees _____

4.Travel expenses _____ 5. Other study related expenses _____

Reporting relationship

42. To whom do you report directly?

Senior SLT	Principal SLT	Medical Doctor	Other (specify)

43. What is the most senior management structure in which SLTs have direct representation in your organisation? _____

44. Are you on a management committee in your organisation? Yes_____ No _____

45. Is this role specified in your job description Yes _____ No _____

46.. Is there SLT representative on the management group which has budgetary/planning/policy responsiblity for your service? Yes _____ No _____

47.Are you involved in policy decisions regarding delivery of SLT services to your target population

Yes _____ No _____

48. Is your clerical support adequate Yes _____ No _____

49. Do you work as part of a team? Yes _____ No _____

50.If Yes, are you part of one team _____ two teams _____ three + teams _____

51. Please identify the other professionals who work on your team(s) :

Speech & Language Therapist/s	_____	1
Psychologist	_____	2
Medical Doctor	_____	3
Surgeon	_____	4
Orthodontist	_____	5
Occupational Therapist	_____	6
Social Worker	_____	7
Physiotherapist	_____	8
Teacher	_____	9
Nurse	_____	10
Other (please specify)	_____1	1

Training/teaching

52. Does your employer expect you to undertake staff training/teaching? YES _____ NO _____

53. Please identify with which of the following groups you undertake training/teaching

	Within your own organisation/employment	Outside
staff	1	
parents/families	2	
student SLTs	3	
other students groups (specify)	4	
professional groups (specify)	5	
public education (specify)	6	

54. The information which you return will be used to formulate policies to guide the development of the Speech and Language Therapy profession in Ireland. Are there issues/concerns which you particularly wish to be addressed in these policies? If so, please list them here.

_____

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE, PLEASE RETURN IT IMMEDIATELY, or by January 10th 1992 at the latest

TO:CLOTHRA NI CHOLMAIN,SENIOR SPEECH THERAPIST,CHEEVERSTOWN HOUSE TEMPLEOGUE DUBLIN 6W.

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