

Let the Children Speak

AN INTO REPORT ON THE SUPPORT SERVICES
AVAILABLE TO PRIMARY SCHOOL CHILDREN
WITH SPEECH AND LANGUAGE DIFFICULTIES



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FOREWORD

The ability to communicate with others through the use of language is a powerful gift which can easily be taken for granted. Speech and writing are so enmeshed into the fabric of our everyday lives and because we have no problems with speaking, understanding, reading or writing we hardly give a thought to the complexity of the skills we have developed. However, there is a minority of children whose ability to understand language or to express themselves through language is immature, different or undeveloped in comparison with their peers. Their ability to use language is limited and they are disadvantaged in a wide range of situations in the school and social environment. These children are in real danger of education disadvantage and social exclusion. The lack of support available to them is a matter of serious concern to INTO members and has been debated at numerous INTO Congresses.

Consequently, the CEC decided to conduct an indepth investigation of the availability of speech and language therapy to primary school children and to examine the operation of special classes for children with specific speech and language disorder. That indepth investigation revealed that there were very serious gaps and regional variations in the provision of speech and language therapy to primary school children. Furthermore, a questionnaire issued to the principals and teachers in the Special Classes for Speech and Language Disorder in October 1999 also showed that there was a severe shortage of places in special classes for specific speech and language disorder and that some classes were even operating without the support of a speech and language therapist and without clear guidelines or recognised and defined procedures.

It is hoped that the factual information contained in this report will prove to be a valuable tool for teachers and that it will answer many of the questions which teachers raise in dealing with children with

speech and language difficulties. The complexity of the processes involved in the areas of language acquisition, language development and the causes and features of the main language difficulties are outlined. The report gives background information on how speech and language therapy as a profession has developed. As the nature of classrooms change teachers are increasingly working with other professionals, this report offers advice and support for those teachers who find themselves in teaching positions where they are working collaboratively with other professionals.

In publishing this document, the INTO's objective is to raise awareness of the wide range of problems associated with the current system. We hope to highlight the very real difficulties being experienced by teachers both in accessing support services for children with speech and language problems and in the operation of the special classes for children with speech and language disorder. We think that the comprehensive recommendations proposed in this report should shape the future direction of speech and language therapy services for children in primary schools. We believe that the policy outlined in this report if implemented by the Department of Education and Science would represent a major improvement in the services available to these vulnerable children.

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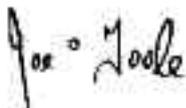
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Senator Joe O' Toole,
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INTRODUCTION

Language comes so naturally to us that it is easy to forget what a strange and miraculous gift it is. All over the world members of our species fashion their breath into hisses and hums and squeaks and pops and listen to others do the same. We do this, of course, not only because we like the sounds but because details of the sounds contain information about the intentions of the person making them. We humans are fitted with a means of sharing our ideas, in all their unfathomable vastness.

Pinter (1999:1)

CHAPTER 1

LANGUAGE

Using language to communicate is something we generally take for granted. Most of us can converse in at least one spoken language. We have learned to read and write with relative ease. Speech and writing are built into the fabric of our everyday lives and because we have no problems with speaking, understanding, reading or writing we hardly give a thought to the complexity of the skills we have developed. The American Speech-Language-Hearing Association (ASHA 1983) defined language as follows:

Language is a complex and dynamic system of conventional symbols that is used in various modes for thought and communication. Contemporary views of human language hold that:

- a) language evolves within specific historical, social, and cultural contexts;
- b) language, as rule governed behaviour, is described by at least five parameters – phonologic, morphologic, syntactic, semantic, and pragmatic;
- c) language learning and use are determined by the interaction of biological, cognitive, psycho-social, and environmental factors;
- d) effective use of language for communication requires a broad understanding of human interaction including such associated factors as non-verbal cues motivation, and sociocultural roles. ASHA (1993:44).

Pinter (1994) explores the human capacity to make use of symbols and code events. This 'language instinct' is powerful and is optimally activated by parents and carers in the period from birth to around three years of age.

LEARNING LANGUAGE

Although written language is normally taught from the earliest stages in the school context, oral language, on the other hand, is normally well developed in children by the age of school entry. Tod and Blamires (1999) describe this early stage of development as follows:

The initial impetus for the adult is to communicate with his/her infant by securing *joint attention*. This is achieved by closely monitoring the child's gaze and commenting on what s/he is doing. When the infant's gaze wanders to another focus the adult follows the infant's line of gaze and continues to comment. This enables two things to happen with time: joint attention to be secured and increased; and language and gesture to be received by the infant and associated with an activity or event which was initiated by the child.

The purpose of language is *social* – the adult wants to relate to her infant and with time (6-9 months) the infant responds by wanting to communicate with the adult ('communicative intent'). A range of strategies are used by the adult to increasingly secure the joint attention and *turn-taking* needed for the development of social communication.

During this period of development the adult uses STRATEGIES which follow the sequence: gain child's attention – modify input to ensure that it is

relevant and understandable – extend and clarify using close monitoring of child’s response and utterances to inform next sequence of language input. Tod and Blamires (1999:15-16).

By the time they enter school most children have well-developed grammar, a large vocabulary and are almost completely intelligible. Their language can be used in the teaching and learning of the curriculum, and their communication skills can be further enhanced as a result of their interaction with the curriculum, their peers and teachers. However, there is a minority of children whose ability to understand language or to express themselves through language is immature, different or undeveloped in comparison with their peers. Their ability to use language is limited and they are disadvantaged in a wide range of situations in the school and social environment. These children are in real danger of educational disadvantage and social exclusion. Their progress is a matter of concern to teachers and they are the focus of the particular concern of speech and language therapists.

SPEECH AND LANGUAGE THERAPY

Speech and language therapists work with children and adults who are having difficulty with communication. They also work with their families, carers, teachers and colleagues to find out why and how communication is a problem. Their aim is to facilitate improved communication. They deal with a variety of problems, ranging from pre-school children who have not developed language normally or have difficulty with pronunciation or fluency; to adults who may have originally developed language normally but have lost the ability to communicate after a stroke, head injury or through loss of hearing. Because of the wide range of possible problems, and the complexity of assessing and working with communication difficulties, speech and language therapists study communication, language, psychology, and

the medical aspects of speech disorders in depth. They also develop practical skills of assessment and treatment. They are aware of the need to work in close collaboration with parents and other professionals. Webster and McConnell (1987) outline the role as follows:

The view of Speech Therapists 'correcting' a child's speech articulation problem on weekly visits to an outpatient's clinic is an outdated one. Speech Therapists make much more important contributions to the overall management of communication difficulties. They will make valuable suggestions for both parents and teachers to use in the natural learning contexts of the home and school. Increasingly, Speech Therapists are working in partnership with teachers and parents, helping to devise strategies which enable the child to take part in the communication environment. McConnell (1987:127).

The speech and language therapy profession is relatively new. In Ireland it was not until the 1950s that professionally qualified therapists were employed. Prior to this speech correction would have been the domain of elocutionists, teachers and clergy. Initially, they were employed to work with people with a mental handicap but gradually their expertise was extended to other groups. In its review of speech and language therapy services, the Irish Association of Speech and Language Therapists (IASLT 1993), detail the growth in employment of therapists from 2 at the end of the 1950s, 19 by 1971, 70 by 1979, and 187 by 1991. At present there are 277 wholetime equivalent posts (IASLT, 1999).

The development of the speech and language therapy profession in this country has been closely linked with its development in the United Kingdom. Brown and Gilbert (1989) detail early developments

in the health and education sectors to deal with children with speech problems. The College of Speech Therapists came into being in 1947. It organised a diploma course which for the next twenty years remained the sole means of entry into the profession in the UK. Following the acceptance of the report of the Committee of Enquiry into Speech Therapy Services in 1972, training was to be at degree level, and for the first time the organisation of speech therapy services was unified under the control of the health authorities. The College of Speech Therapists continued to regulate professional entry through its power to recognise graduates as being qualified to practise. The College also monitored the first training course which was established in Ireland in 1969 under the auspices of the National Rehabilitation Board. A degree course replaced this diploma course in 1977 and the power of professional accreditation passed from the UK College to the Irish Association of Speech and Language Therapists in 1992. The Irish Association of Speech Therapists had been formed in 1971 and was later renamed the Irish Association of Speech and Language Therapists (IASLT) following a similar renaming of the UK body to the Royal College of Speech and Language Therapists. Both bodies maintain close links.

The arrangements for the education of Speech and Language Therapists in the Republic of Ireland are detailed by the IASLT (1993). This education takes place in the School of Clinical Speech and Language Studies, Faculty of Health Sciences, Trinity College. Prior to 1979, as the School of Remedial Linguistics, it was part of the Arts Faculty. Currently it is a four-year degree programme leading to a B Sc Honours Degree in Clinical Speech and Language Studies. There is reciprocal recognition between the Trinity College course and courses in the UK recognised by the Royal College of Speech and Language Therapists. The aims of the course are set out by the IASLT (1993) as follows:

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. IASLT (1993:7).

The Royal College of Speech and Language Therapists (1996) state that the purpose of studying the core disciplines of language pathology, linguistics and phonetics, anatomy and physiology, audiology, psychology and research methodology is:

- 0 to understand those principles in each subject which are relevant in analysing communication and related cognitive disorders, and to understand their role in the speech and language therapy context;
- 0 to understand research within these disciplines which relate to the cognitive, emotional and social dimensions of communication disorders.

Royal College of Speech and Language Therapists (1996:233).

The broad base of knowledge which speech and language therapists have to work from makes it impractical to cover all areas in depth during undergraduate training. The IASLT (1993) urge therapists to “pursue studies at post-graduate level in relevant areas and at appropriate stages during their professional career”. Leahy (1989) makes the point that:

Educational alternatives need to be discussed with future service provision given priority. The question of whether specialisation should begin at undergraduate level, with perhaps a course offered

for those wishing to specialise in working with children only, or alternatively with adults only, needs to be addressed. Leahy (1989:321).

The issue of specialisation in working with children only is an important one in the context of the issues being raised in this report.

The professional activities undertaken by speech and language therapists in their role in maximising the interpersonal communication of clients have been set out, by the IASLT (1993), as including assessment and diagnosis, the therapeutic role, training and education of others, the preventative role, administrative work, research and professional development.

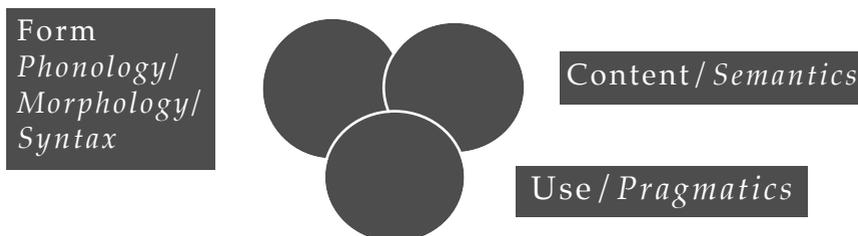
LANGUAGE : A CLOSER LOOK

Understanding difficulties that may arise in the development of language competence can be a very complicated task. Chiat (2000) writes:

Some children can hear; they can speak; yet their language is not developing normally. The source of their difficulties is not immediately obvious. It lies beyond the auditory and motor ends of speech, in processes which are hidden from consciousness and from direct observation. Chiat (2000:262).

Daines *et al* (1996) also explain how language difficulties are not always what they appear to be on the surface. For instance, a difficulty with speech sounds may result in problems with grammatical structures, which will also affect the ability to express meaning. A difficulty with learning the meanings of words may lead to difficulty with the use of appropriate expressions and may cause a child to appear socially 'odd'. The linguistic description proposed by Bloom

and Lahey (1978) is a starting point in trying to identify whether the child's difficulties appear to be predominantly in the content, the form or the use of language. As children's language develops aspects of *content*, *form* and *use* come together and overlap as in the following diagram:



The form of oral language is made up of consonant and vowel speech sounds, which are combined to form meaningful morphemes and words, which are then combined in a particular order to form phrases and sentences. Form relates to the *syntactic* or grammatical level of language.

The content of oral language is what we talk about, our ideas and concepts. It is the way in which our words and sentences are endowed with meaning. Content relates to the *semantic* level of language.

The use of language is how it is used for a variety of purposes with different audiences. We use language for a broad range of tasks in a wide variety of settings. How we use language will have a major impact on our effectiveness as communicators. This is what linguists call the *pragmatic* level of language.

CHAPTER 2

DISORDERS OF COMMUNICATION

There are many and varied causes for language difficulties. However, they may be grouped according to whether they are *congenital*, *developmental* or *acquired*. Congenital disorders such as cleft lip / palate, Down's syndrome or cerebral palsy are present either before or from birth. Developmental difficulties, either generalised such as slowness to acquire language or specific such as stuttering, become apparent in early childhood. Developmental difficulties may arise because of a *delay* in the normal sequence of development or they may arise because the developmental process itself is *disordered* or *impaired*. Acquired disorders are as a result of illness or injury such as stroke, head injury or cancer of the larynx.

Communication disorders will manifest themselves in many different ways but it is important to bear in mind that all aspects of language are interrelated and difficulty in one area may have consequences for other areas. Some of the main ways in which school-age children present with *developmental* language difficulty will now be described. We will look at:

- + Attention and listening.
- + Understanding and comprehension.
- + Expression.
- + Other difficulties.
- + Specific language impairment.

ATTENTION AND LISTENING

Attention is necessary if we are to take in information. Listening involves the development of auditory attention. Difficulty with paying attention to linguistic information will inevitably lead to problems in learning to understand language. Daines *et al* (1996) offer this description of children with attention and listening difficulties.

These children may be easily distracted and seem more interested in sounds and activities outside the room than what is being said directly to them. They may be more interested in visual than auditory activities. Children with language difficulties may not be very skilful at controlling their own attention. They may therefore miss sounds, words or large chunks of language so that they do not grasp the whole meaning. Spoken instructions which contain too much information at once may therefore cause great difficulty. Daines *et al* (1996:13).

Poor listening on the part of a child may be an indication of:

- 0 hearing loss;
- 0 a poor memory for speech sounds, words or phrases;
- 0 emotional insecurity and anxiety;
- 0 difficulties with the comprehension of language;
- 0 difficulties with pragmatics, especially in relation to identifying topics and following changes in topic. Daines *et al* (1996:14).

UNDERSTANDING AND COMPREHENSION

Some children even though they can hear, pay attention, listen and speak clearly still have difficulties in understanding language. Failure to consistently attach meanings to words; especially when the words relate to concepts of size, shape, colour, position or time; will have serious consequences for the child's functioning in the classroom in a range of curricular areas. At a more complex level there may be difficulties with linking words together. Comprehension difficulties often go undetected at home because conversations are supported by familial routines and expectations. Children may have difficulty in moving from the use of language for social purposes to the use of language as a structured system for recording knowledge. Children may, for instance, use and understand the word 'more' in a social context, as in 'I want more cake', but have difficulty with the mathematical concept of 'more', as in 'nine is two more than seven'. Daines *et al* (1996) offer the following advice to teachers to assist comprehension.

It is important for teachers to be aware of their own language and to find extra strategies for supporting children with comprehension difficulties. Such strategies could include:

- 0 Simplifying sentences.
- 0 Rewording sentences.
- 0 Repeating key sentences and asking the child to repeat back what they have to do.
- 0 Keeping the order-of-mention the same as the order-of-action.
- 0 Interweaving directions and actions so that large chunks of language do not need to be understood and remembered.

- 0 Marking clearly when attentive listening is required. Selectively naming children with poor listening attention.
- 0 Identifying topics clearly, minimising topic changes and signalling these changes before they happen.
- 0 Working specifically on the vocabulary that is required. Do not assume understanding of basic concepts... Such as 'middle'.
- 0 Using more literal language for those children who have difficulties with social language use and meaning.
- 0 Being alert to one's use of idioms such as: 'I was just pulling your leg'. Daines *et al* (1996:31).

EXPRESSION

Children having difficulty in expressing themselves may have a problem in one or more of the following areas:

- 0 Sounds (Articulation/Phonology)
- 0 Words (Vocabulary/Morphology)
- 0 Word Order (Grammar/Syntax)
- 0 Appropriate to the situation (Pragmatics)

■ Sounds

By school entry age a child should have most of the speech sounds. A child who does not may have a speech problem. Some children may have a limited repertoire of sounds in their speech and may favour these sounds and substitute them in place of the sounds that they lack. Parents may crack this code for themselves and thus understand the child. Other children may be less consistent in their production of sounds and may have difficulty co-ordinating the fine motor movements required for speech. In extreme cases alternative ways of

expressing themselves have to be taught. These may involve various signing systems sometimes with IT support. Lack of intelligibility is a difficulty that needs to be addressed as early in the child's life as possible. By age seven or eight such problems may lead to difficulties with social and emotional adjustment. The following advice is

Sounds

WHAT TO LOOK FOR	HOW TO CHECK	WHAT TO DO
3 Child who cannot be understood.	3 Listen carefully as child reads or names pictures.	3 Hearing Test.
3 Child sounds muddled.	3 Encourage child to imitate you.	3 Check with family.
3 Has only a few sounds.	Note how each word is said.	3 Refer to SLT.
3 Says the same word differently at different times.		3 Do not repeat the incorrect pronunciation.
		3 Model the word correctly in a sentence.

■ adapted from Barry and Wright (1996).

Words

Children may have specific difficulties learning the meaning of words. Their speech may sound clear and their sentence structure appear appropriate but their vocabulary may not be adequate. Words are symbolic; some are linked directly with objects (e.g. 'table') or activities (e.g. 'jump'), others are more abstract (e.g. 'if' 'where'). Difficulty with words for some children may be the result of lack of experience, but for others it may signify a specific difficulty with association or memory.

Vocabulary		
WHAT TO LOOK FOR	HOW TO CHECK	WHAT TO DO
3 Can't remember names of objects or people.	3 Choose an unfamiliar book. Talk about pictures. Can child name them? Try again next day.	3 Teach a topic 'fruit'. Check recall after a week or two.
3 Has trouble learning new words.		3 Check with parents and other teachers.
3 'This' 'that' 'thing'.	3 If child cannot name an object, see if he can say what it is used for.	3 Refer to SLT.
3 Is not always fluent.		

■ The following advice is adapted from Barry and Wright (1996).

Word Order

Before dealing with word order it is also necessary to discuss the grammar with words at the level of morphemes. These are the small units of grammar which carry meaning: 'ed' and 'ing' on the end of a verb will indicate past or future tense; 's' may denote plural or possession. For a child who cannot express these grammatical differences it is important to determine whether the problem is at the level of sound production or is a difficulty with grammatical understanding. English grammar or syntax is also determined by word order. If children have difficulty in this area their sentences may be very short or they may sound odd because the word order is incorrect. Where a child has a difficulty with syntax, speech may sound like a verbal telegram (telegrammatic speech). 'Me go yard'

may be acceptable for a three to four year old but for a six year old one would expect to hear 'I want to go out to the yard'. When telegraphic speech is found in association with poor articulation

Syntax

WHAT TO LOOK FOR

- 3 Missing words out of a sentence.
- 3 Words in the wrong order.
- 3 Speech sounds like a telegram.

HOW TO CHECK

- 3 Listen carefully.
- 3 Note down exactly.
- 3 Check for words left out or for unusual word order.

WHAT TO DO

- 3 Provide the correct full length version after the child has spoken.
- 3 Do not ask the child to repeat the correct version.
- 3 Do not mimic.
- 3 Refer to SLT.

■ understanding will be extremely difficult. The following is adapted from Barry and Wright (1996).

Appropriate to the situation (Pragmatics)

The IASLT (1993) define disorders of pragmatics as follows:

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 overly-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). IASLT (1993:6)

Children with pragmatic type difficulties will have more difficulty with the content and use of language than with its phonological and syntactic form. Their problems manifest themselves more readily in informal conversational contexts rather than in formal test situations. Donaldson (1995) states that their speech may be correct in itself but is irrelevant or tangential in relation to the conversation that preceded it. She goes on to outline how they are prone to take overly-literal interpretations of other peoples' speech, have difficulty in taking turns appropriately in a conversation, sometimes chatter incessantly and give echolalic responses, sometimes have large vocabularies but also have tendencies to use circumlocutions. She suggests that these linguistic difficulties are similar to but usually less severe than those shown by autistic children. Daines *et al* (1996: 23-26) outline some classroom activities to support children with pragmatic difficulties. They include:

- 0 Activities involving making inferences.
- 0 Activities involving issues of shared knowledge and provision of sufficient information.
- 0 Consideration of causal relationships.
- 0 Non-verbal abilities.
- 0 Turn-taking activities.
- 0 Awareness of self on a group.
- 0 Conversation skills.

The following advice is adapted from Barry and Wright (1996)

Pragmatics		
WHAT TO LOOK FOR	HOW TO CHECK	WHAT TO DO
3 Has problems taking turns in a conversation.	3 Listen to child talking with another adult; another child, and with a group of children.	3 Complex area. 3 Refer to SLT.
3 Moves from topic to topic rapidly, for no reason.		
3 Cannot switch topics and goes on and on.	3 Watch how s/he attracts adult attention. 3 Note if s/he can take turns.	

OTHER DIFFICULTIES

Speech and language therapists are also concerned with disorders of fluency, voice and swallowing. Fluency relates to the smoothness with which sounds, syllables, words and phrases are joined together during oral language. The IASLT (1993) state that:

Fluency disorders (stammering/stuttering, cluttering) are characterised 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. Early intervention is necessary as anxiety may increase the severity of the disorder and result in negative social and educational outcomes. IASLT (1993:27).

In the case of children in infant classes it is important to note that young children may pass through a stage of 'normal non-fluency'. They are unaware of their non-fluency and will pass easily back to fluent speech if they remain unaware. Teachers and parents are advised to ensure that nothing in their own behaviour makes the child aware of his or her speech. Don't tell the child to slow down, hurry up, start again, take a deep breath, or discuss the child's speech in his/her hearing. Do listen quietly, wait until the child finishes and listen to what s/he has to say rather than how it is said. However, it is advisable, with parental consent, to contact the speech and language therapist at an early stage if the child's non-fluency becomes a cause for concern.

A child with a voice problem usually presents with a hoarse, husky and/or breathy voice. If this persists then referral to a speech and language therapist is indicated. Voice problems are usually caused by shouting, screaming, throat clearing, whispering (can be as harmful as shouting) and using too high a volume when reading or conversing.

Speech and language therapists also have a role in the identification and management of disorders of swallowing. This becomes a problem when the swallow mechanism is impaired and eating and drinking may lead to choking or aspiration. This situation can develop after a stroke or can be associated with such conditions as cerebral palsy or cleft palate.

SPECIFIC LANGUAGE IMPAIRMENT / DISORDER

Special provision is made in the primary school system for children with specific language impairment. Mogford (1989: 3-6) notes that language is a robust aspect of human development which emerges in more or less adequate form even in apparently poor environmental circumstances. It is surprising then that some children growing up in promising environments fail to develop language skills. These children, who are said to suffer from a specific language impairment, are thought to have a difficulty in the process of learning language which not only leads to delay but a distortion of the pattern of language development. These children will present with some or all of the disorders described above. The difficulties will, in the case of these children, be severe and will be best described as disordered or impaired rather than delayed. They will have a significant discrepancy between their verbal and non-verbal abilities. Their language difficulty will also be their primary difficulty and not a secondary effect of some other condition or disorder. Such children will be considered for enrolment in Language Units or Language Classes attached to certain primary schools, or, for inclusion in applications for the appointment of full or part-time resource teachers. The Department of Education and Science (Circular 8/99) states that such children should meet each of the following criteria to be included for resource teacher applications:

- 0 assessment by a psychologist on a standardised test of intelligence which places the non-verbal or performance ability within the average range;
- 0 assessment on a standardised test of language development by a speech therapist which places performance in one or more of the main areas of speech and language development at two standard deviations or more below the mean, or at a generally equivalent level;

- 0 the child's difficulties are not attributable to hearing impairment; where the child is affected to some degree by hearing impairment, the hearing threshold for the speech-related frequencies should be 40Db;
- 0 emotional and behavioural disorders or a physical disability are not considered to be primary causes;
- 0 children with speech and language *delays* and *difficulties* are not to be considered under this category.

The definition used by the Department of Education (Ireland) (1993), to indicate which pupils should be catered for in special language units attached to mainstream schools, is as follows:

Pupils with specific speech and language disorders are those whose non-verbal ability is in the average band or higher and whose skill in understanding or expressing themselves through the medium of spoken language is severely impaired. Their disability is not attributable, however, to factors such as defective hearing, emotional or behavioural disorders or a physical condition. The disorders may involve difficulty with one or more of the main components of communication through spoken language, receptive and/or expressive, such as the patterning and production of speech sounds, the message content, the syntax and grammar, or the use of speech in interacting with other people. Department of Education and Science – Ireland (1993:91-92).

This definition is very much in keeping with the ICAN (1988: 2-3) guidelines for similar classes in the UK. These guidelines set out a definition of specific language impairment by excluding language

difficulties caused by physical disability, severe or moderate learning difficulty, behavioural and emotional problems, hearing loss, autism, dyslexia, and environmental deprivation. They include four broad groups of children whose language disorder is their primary learning difficulty:

- 0 children with phonological/grammatical problems in expressive spoken language;
- 0 children with phonological/grammatical problems who also have difficulty in understanding what is said to them – a receptive disorder;
- 0 children with problems in the areas of semantics (meaning) and/or pragmatics (use of language);
- 0 children with an articulatory disorder.

Lyons and Moriarty (1997), looking at the issue from the perspective of a language unit teacher and therapist make the following points about children with specific language disorder.

These children may exhibit:

- (a) difficulty in understanding what is said to them;
- (b) difficulty in expressing needs, thoughts and feelings, in developing vocabulary and using well formed sentences;
- (c) difficulty in thinking through ideas, taking an equal part in conversation and keeping to the subject being discussed;
- (d) poor concentration and listening skills, often preventing progress in the classroom;
- (e) poor motor control which may affect a child's ability to produce and co-ordinate the rapid tongue movements required to organize the sequence of sounds necessary for speech;

- (f) associated educational, emotional and behavioural difficulties and problems in social development stemming from communication problems. Lyons and Moriarty (1997:1).

Reid and Donaldson (1993: 318-337) note that, although children with specific language impairment show grossly normal development in non-linguistic areas, there are “subtle difficulties and differences in some aspects of non-linguistic ability”. They argue that it is not always clear whether such difficulties are causes or consequences of the linguistic problems. They state that:

Non-linguistic skills which are usually acquired with the help of language may be less well developed in children with a language impairment. Thus the consequences of SLI will not necessarily be restricted to the area of communication. Reid and Donaldson (1993:319).

They go on to review some of the research which has been done to find a single underlying cause for specific language impairment. They point out that the notion of a fundamental auditory perceptual disorder is one that has fared better than other accounts for specific language impairment but the verdict on a causal link remains not proven. Their main point, however, is that for teachers and therapists working with SLI children the notion of a single underlying cause does not seem reasonable in the face of evidence of great individual differences between children who are grouped together because of the common factor of a significant degree of language impairment. They argue that the greatest advances over the past 20 years have come about, not from a search for elusive causes, but from a detailed examination of the particular difficulties faced by individual children. This has led to an increasing awareness that SLI “may be nothing more than a convenient umbrella term, bringing together a range of types of

impairment which may or may not be mutually exclusive". They conclude:

The elusiveness of a single underlying cause for specific language impairment may be partly due to the heterogeneity of the linguistic problems which are covered by the diagnostic label 'SLI'. The linguistic problems which characterise children with SLI vary not only in severity but also in whether they affect comprehension, production or both, and in terms of which linguistic levels (i.e. phonological, syntactic, semantic or pragmatic) they influence. Reid and Donaldson (1993:333).

Conti-Ramsden and Adams (1995: 1-11) state that identification of children with SLI is not straight-forward given the heterogeneity of the language problems in these children, the diversity in the aetiology, our lack of understanding of the factors affecting prognosis, and the use of exclusion criteria in identification. They argue that our concepts of SLI are derived mainly from research on preschool SLI. They go on to make the case that, despite the definition 'par excellence' of SLI which excludes children with cognitive difficulties, as children with SLI grow older and enter the school years it becomes more obvious that a substantial percentage of them will have significant learning problems. It is only when the cognitive demands increase that a true picture of these children and their needs emerges.

A Scottish Office report (HM Inspectors of Schools, 1996: 6), sums up the dilemma by admitting that "the causes and nature of speech, language and communication disorders are complex and not yet fully understood." Bishop (1997) makes the point that the "less well we understand a condition, the more varied and inconsistent is the terminology that we use to refer to it" Bishop (1997:21). She critically evaluates the manner in which the diagnosis of specific language

impairment is arrived at and challenges both the use of statistical cut-off points and the practice of establishing a mismatch between language and non-verbal IQ. She argues that “in our current state of knowledge there seems to be no justification for using stringent research-based criteria to decide who should receive remedial help” Bishop (1997:32).

McMillan (1994: 11-14), writing as a psychologist outlines the process involved in the diagnostic assessment of children being considered for language unit placement. He stresses the multidisciplinary nature of such assessment; the involvement of a paediatrician to provide a detailed medical assessment; a speech therapy assessment; a psychological assessment; a school or nursery report; and parents’ reports of their child’s language skills at home. He outlines in detail the steps the psychologist will take to ascertain if the child is intellectually within the normal range, so as to satisfy the definition of specific language handicap, for the purposes of admission to a language unit. He summarises:

One simply establishes that the child in question has speech and language skills which are very poor for their age, measures non-verbal ability and, if there is a marked discrepancy between language and general ability, concludes that the child has a specific language problem. McMillan (1994:13).

However, he questions the assumptions that link cognitive development with language development. He also calls into question the lack of clear agreement on the degree of language delay necessary to constitute a handicap. He argues that there may not always be a neat verbal/non-verbal skills discrepancy in children with speech and language difficulties and that rather than being ‘specific’ the learning difficulties in question are frequently pervasive and may involve social, behavioural, motor, and perceptual skills. He cautions against the over-reliance on test scores and suggests that it is important to

look at the child's whole range of abilities, through observation of real life situations, for evidence of possible areas of strengths.

The operation of language classes will be looked at in more detail in a later section of this report and recommendations about improving the service will be made.

CHAPTER 3

THE OPERATION OF SPEECH AND LANGUAGE THERAPY SERVICES

The Irish Association of Speech and Language Therapists' (1993) review outlines the structures underlying the delivery of speech and language therapy services. The service has developed in this country under the Department of Health and Children. The majority of speech and language therapists are employed directly by Health Boards. Within the Health Boards the speech and language therapy service is provided primarily under the Community Care Programme and is organised on the basis of Community Care areas. Speech and language therapists working in community care provide a service in a variety of settings including Health Centres, Child and Family Centres, Hospitals and Schools. The IASLT review expresses concern about the difficulties therapists may experience in both hospital and school settings, because of ambiguity as to their formal position, and confusion about reporting /accountability relationships. Some speech and language therapists are employed directly by voluntary hospitals or voluntary agencies. The lack of co-ordination between statutory and non-statutory agencies has been cited as a reason for the uneven development of services. The IASLT review criticised the lack of consultation with the profession about service delivery issues by management agencies in the health sector.

Enderby (1989) outlines the levels of provision that are necessary to provide a reasonable service. She writes:

If an equitable service is to be implemented and if current methods of intervention are to be pursued then it would appear that at least 23.37 speech and language clinicians per 100,000 population is

justified. Without this level of staffing, service provision is spread thinly and the allocation is not usually done on a rational basis. Enderby (1989:50).

The IASLT (1993) review estimated that Enderby's figures suggest the need for 818 speech and language therapists. This is in contrast to the 187 such posts that existed in 1991. An IASLT (1998) document showed that by 1998 this figure had only risen to 277 whole-time equivalent posts. This figure would need to treble if the incidence of speech and language problems, as estimated by Enderby, is to be addressed adequately.

REFERRAL PROCEDURES FOR SPEECH AND LANGUAGE THERAPY

Referrals

In almost all Health Board Community Care Areas an open referral system is in operation. Children may be referred by public health nurses, doctors, teachers, psychologists, social workers, parents, and, in the case of adults self-referral. In the case of children referral is accepted on the understanding that parental consent has been obtained. Referrals should be sent to the Principal Speech and Language Therapist of the relevant Community Care Area. The Wexford Community Care Area of the South Eastern Health Board is an exception in that it only accepts referrals from a child's GP.

Initial Assessment

Following referral there may be a waiting period for initial assessment. This waiting period will vary from region to region depending on the available resources at the time. In most cases this waiting period should be no longer than four months. Initial assessments are generally given a high priority so that clients in need of urgent attention are prioritised at an early stage. The purpose of the initial assessment is to determine the presence or absence of a

communication disorder. Initial assessment may include taking a case history, informal standardised measures, formal standardised tests, a physical examination of the oro-facial area, and an evaluation of the client's communication environment (home and/or school in the case of a child). The speech and language therapist may require additional information from other professionals. Ear, nose and throat examination, audiological assessment, psychological assessment, and neurological evaluation may be required in certain cases. If initial assessment indicates that communication is not the problem then the client is discharged or referred on an appropriate service.

Diagnosis, Planning, Intervention and Discharge

Information gathered through the assessment procedures is interpreted to make clinical judgements about the presenting communication disorder. Assessment information is evaluated and used for planning therapy objectives and for measuring progress during therapy and prior to discharge. Clients will be put on a waiting list for therapy. The length of time on the waiting list will be dependent on the available resources within the Community Care Area and on the severity and type of the presenting disorder. A child with very severe speech or language problems will be seen the soonest, whereas children with minor speech and language problems will wait the longest. Waiting periods for therapy can range from up to three months to over twelve months (IASLT 1993: 49). Therapy may be done *directly* with the client or *indirectly*, where the speech and language therapist will work with parents or other family members. Therapy may be *intensive* (daily) or *non-intensive* (weekly or less). Therapy may be *ongoing* (e.g. weekly over a long period of time) or offered in *blocks of time* (e.g. once weekly for a number of weeks, a break, then a further block of time). Therapy may be delivered on an *individual* or *group* basis.

Discharge from therapy ideally occurs when the goals of therapy have been achieved. However, failure to attend appointments or lack of co-operation may also lead to discharge.

MOVING FROM A HEALTH TO AN EDUCATIONAL MODEL

The issue of whether speech and language therapists working with school-age children should be employed by the education rather than the health authority and the relationship between both has been raised. There are a number of reasons why this question is being addressed in recent years. Firstly, there is an increasing awareness that providing for children with communication difficulties is, in most cases, an educational rather than a medical issue. Secondly, the link between early difficulty with listening and speaking skills and later problems with reading and spelling skills has become much clearer in recent years. Thirdly, the developments in provision for special educational needs, including the establishment of language units attached to mainstream schools, has promoted collaboration between teachers and therapists and provided them with common goals in relation to meeting the needs of children with language difficulties.

Speech and Language Therapy as an Educational Provision

The issue of a health or educational emphasis for speech and language therapy is often characterised as one between clinic or classroom. Donnelly (1992), from an American perspective, outlines the advantages of moving away from the traditional pull-out model of therapy in a 'speech' room removed from the classroom, towards an educationally-based model in a school setting.

- 0 Teacher and peer behaviour influences the social effectiveness of a child's communication attempts.
- 0 Carry over of progress from the clinic to the classroom can be problematic.

- 0 Language difficulties of school aged children affect their academic performance.
- 0 The pull-out model singles out the child as being different and relegates his/her educational needs to a secondary position to communication needs.
- 0 When the teacher is not involved s/he cannot participate in carry over of newly learned language patterns into the child's academic programme.
- 0 The pull-out model does not address the communication demands of the classroom.

She writes:

The children receive speech therapy as part of their academic program and not as an add-on service. This move has been so well received in the US that currently approximately ninety percent of all children assigned to special education classes are now receiving speech therapy in their respective classrooms. Additionally, over half of all mainstreamed handicapped children are now served in the classroom. This model is proving to not only have enormous benefits to the language impaired children but to all children in the classroom as well. Donnelly (1992:53).

Reed (1992: 58-69) reporting on a Canadian school board district also notes a move away from direct pull-out therapy. She outlines a system of classroom based assessment and intervention, facilitated by a process of collaborative consultation, where the aim is not to provide 'therapy in the classroom' but to use the language of the classroom curriculum as the context and the content of the intervention. She defines collaborative consultation as "an interactive process that

enables teams of people with diverse expertise to generate creative solutions to mutually defined problems.” She points out that the expertise of the speech-language pathologist is relevant to the whole education of students along the oral written language continuum.

Becton (1999) outlines the position in the United Kingdom. She writes:

While some UK speech and language therapists are employed by Local Education Authorities (LEAs), most therapists providing services to schools are employed by the Trusts of the National Health Service (NHS). The Code of Practice on the Identification and Assessment of Special Educational Needs, rather confusingly, states that speech and language therapy may be regarded as either educational or non-educational provision (Department of Education, 1994).

It also points out that the prime responsibility for the provision of speech and language therapy services rests with the NHS. The Code goes on to state that where the NHS does not provide speech and language therapy for a child whose statement specifies it as an educational need, then the ‘ultimate responsibility’ for making the provision lies with the LEA (Department for Education, 1994). Becton (1999:59).

The issue of the relationship between Health and Education in the provision of speech and language therapy services to schoolchildren in the UK is currently the subject of a working group which is due to report by the end of 2000. An interim discussion document sets out the following guidelines on the role of speech and language therapists working in schools:

A clear statement should be made which sets out key features of the role of SLTs working with children of school age. We would expect this to include:

- 0 therapy for children of school age is best carried out collaboratively within the school context;
- 0 where a child's special educational needs include communication difficulties that require SLT involvement, then SLT provision should be regarded as an educational provision;
- 0 the traditional tasks undertaken by SLTs (that is assessment, diagnosis and therapy) should all be carried out in collaboration with teachers;
- 0 in addition to traditional tasks, SLTs should be expected to support schools in the differentiation of the content, teaching style and outcome of the curriculum for children with speech and language difficulties with a particular focus on language in the classroom context of both peers and teachers;
- 0 SLTs can also be expected to provide education and training in aspects of language, language acquisition and speech and language difficulties as it relates to the classroom and to the content of the curriculum.

The Irish Association of Speech and Language Therapists (1993: 36) has accepted that speech and language therapy for school-age children is an educational provision. They note the fact that in many other countries speech and language therapists are routinely employed by Education Authorities and work with teachers to provide an integrated service. They call on the Irish Departments of Health and Education to formally recognise and address the issue of the role of speech and language therapists in schools.

The implications of accepting speech therapy as an educational provision are set out by Cranmer (1992: 3-7) as follows:

- 0 The context in which special needs are met is primarily educational but where the therapist has a vital part to play. It cannot be seen just as a convenient location to provide therapy with educational activities added on to fill the gaps between therapy sessions.
- 0 Therapists and teachers will need to acknowledge educational objectives and align their work with curriculum requirements.
- 0 There needs to be a substantial educational element in the initial training of therapists as well as greater opportunities for in-service training.
- 0 Shortfalls in the provision of speech therapy need to be addressed, with both Education and Health discharging their respective responsibilities.

Links with written language difficulties

In addition to the arguments put forward above, there is also a growing body of evidence which suggests that speech and language therapists may have a role to play in the area of written language difficulties. Layton and Deeny (1996: 129-145) outline a phonological awareness training programme for four to five year olds, developed collaboratively by teachers and therapists and aimed at early identification of children with a disposition towards literacy difficulties. They “look forward to the day when the teacher/therapist skill-mix routinely informs and directs the enhancement of early literacy skills”.

Nash (1993: 338-353) argues that language disordered children may be at risk for later problems with reading and spelling, that different types of difficulty may be experienced, and that children with dyslexia may have high level speech and language disorders.

Stackhouse (1989, 1996) has outlined the relationship between spoken and written language disorders. This, he argues calls into question the role of the speech and language therapist in reading and spelling disorders. He writes (1996):

For a number of years spoken and written language were viewed and managed separately – the speech and language therapist ‘treated’ the speech and spoken language while the teacher ‘taught’ reading and spelling. It is becoming clear, however, that in some cases the reading and spelling difficulties experienced by a child are an extension of the phonological processing deficit in earlier or persisting speech difficulties. Stackhouse (1996:20-21).

Collaboration

McCartney and Van der Gaag (1996) link the issue of speech and language therapists working in educational settings with collaborative work by teachers and therapists, and professional development of teachers.

Therapists and teachers increasingly recognise that the traditional one-to-one intervention model used by therapists in schools does not maximize the child’s communication potential. It does not promote carryover of new skills, nor does it allow for teachers and therapists to establish joint aims and objectives for the child. Increasingly, examples can be found in school settings where teachers undertake further training in order to develop specialist knowledge on language and communication and therapists work almost exclusively alongside teachers in the classroom. McCartney and Van der Gaag (1996:318).

Wright (1994: 334-335) suggests that a separate school speech therapy service be established and staffed by therapists who either train initially as teachers or train only to work with children. Under this system a large proportion of their course content would be similar to that covered in initial teacher training and they would start their professional careers with a “greater understanding of the classroom as a learning environment”. This system would facilitate collaboration between both professional groups.

Kersner (1996) also makes a very explicit link between the need for both teachers and therapists to acquire knowledge and awareness of each other’s areas of expertise and the need for effective collaboration. She writes:

It would certainly seem that professionals work best together when they have a shared language and a shared understanding of each other’s work, and that this is more likely to lead to a collaborative rather than an expert model of working... Professional development opportunities must be created for teachers and therapists to be specifically trained regarding the needs of the client group and to be able to understand each other’s practice so that they can communicate and collaborate more effectively. Kersner (1996:26).

DiMeo, Merritt and Culatto (1998: 49-54) argue that collaboration between teachers and speech and language pathologists (SLPs) is not easy to achieve and will involve changes in methods and delivery of instruction. Each person will have to involve the other in assessment, planning, and intervention. They stress the interpersonal nature of the task and use the analogy of a personal friendship. They describe three stages through which a collaborative relationship progresses. The levels are described in terms of compliance, cooperation and collaboration and are described as follows:

The first level... is described as *Compliance*... The major purpose of this level is to develop a stable communication base... The Compliance Level is typical of SLP programming which is primarily 'pull-out' to a separate setting, but it can provide valuable groundwork for higher level interactions.

The second level of collaboration is described as *Cooperation*... At the Cooperation Level both have developed knowledge of each other as people and professionals, which serves as a foundation for their interactions. Predictability and acceptance of the other person is characteristic, and it is during this level that practitioners begin to request information regarding intervention options from the other.

The highest level of professional interaction is *Collaboration*, which is characterized by trust, mutual respect, and support. Acknowledgement of professional expertise as well as an acceptance of relative professional weaknesses are evident. Honest and open communication between collaborators allows free discussion of needs, plans, and actions, even when these interactions represent intrusions of time. DiMeo, Merritt and Culatto (1998:51-53).

In their review of provision in Scotland, HM Inspectors of Schools (1996: 33-34) pointed out that one of the most critical factors determining the quality of the provision for language impaired pupils was the quality of the partnership between speech and language therapists and teachers. They describe the hallmarks of effective collaboration as being mutual trust and respect, joint goal-setting, joint training, and parental satisfaction with the provision. They note

that this type of productive collaboration needs to be actively promoted by both school and speech therapy managers through the allocation of time for teachers and therapists to plan, joint staff development activities, and through the monitoring and reviewing of working practices. They conclude that the quality of teacher-therapist partnerships needs to be improved.

Reid *et al* (1996), in a major report to the Scottish Office on the role of speech and language therapists in the education of pupils with special educational needs, found evidence of collaborative practice among speech and language therapists, teachers and parents. Collaboration was however more evident in special educational facilities than in mainstream schools where many speech and language therapists continue to provide only a traditional withdrawal-based style of therapy. They sum up the main purpose of their research as follows:

In summary, collaboration amongst professionals (especially teachers, speech and language therapists and educational psychologists) and between professionals and parents is widely accepted as a desirable goal. However, the crucial question of how such collaboration may be achieved most effectively is, to date, largely unanswered. Reid *et al* (1996:1)

They propose that collaboration ideally would be a process which would begin with joint assessment, and would lead on to joint identification of common goals, and joint planning of educational and speech and language therapy programmes. They argue that joint working, although not a necessary component of effective collaboration, is however a valuable way of “helping teachers and speech and language therapists to evolve compatible styles of working, so that pupils experience an integrated programme rather than a series of diverse approaches” Reid *et al* (1996:96).

In detailing the barriers to collaboration, which were highlighted during the interviews they undertook, the following points emerged:

- 0 Teachers and speech and language therapists work for different employers and have different working conditions and different codes of professional ethics.
- 0 Historical barriers may exist between professionals and there may be a feeling that by sharing knowledge and expertise they may be 'doing themselves out of a job'.
- 0 Professional jargon may act as a barrier.
- 0 Teachers and speech and language therapists belong to professions where working alone has been the norm. As a result they may feel threatened by having others observe their work.
- 0 There is little if any pre or post-qualification joint training available to teachers and speech and language therapists in working collaboratively.
- 0 Bureaucratic difficulties associated with decision making and financial arrangements across a number of different agencies may hinder collaborative action.
- 0 Speech and language therapists in particular may have large caseloads and may belong to many different teams.
- 0 There may be problems about sharing information because of different ethics and codes of practice on confidentiality.
- 0 Some individual teachers and speech and language therapists do not see themselves as part of a team.
- 0 Lack of time is a major problem for all professionals working with pupils in schools. Collaborative working is not a short cut and may indeed use up more time than working in isolation. Reid *et al* (1996:97-98).

They conclude:

Teachers and speech and language therapists may not have the power to change how they work in the ways necessary to enable effective collaboration. Their managers and employers need to recognise the importance of collaboration and give priority and active support to collaborative initiatives. Reid *et al* (1996:99).

Wright (1994: 328-339) came to the following conclusions about collaboration between teachers and therapists:

- 0 There was overwhelming agreement from both teachers and therapists about the importance of collaboration.
- 0 Collaboration occurred least during the assessment process.
- 0 The feeling of being appreciated by those they worked with was the most common factor cited as facilitating collaboration.
- 0 The most frequently cited benefit of collaboration was an increase in knowledge and encouraging exchanges of knowledge may be one way of facilitating collaboration.
- 0 Disadvantages ranging from fatigue to loss of professional autonomy or control were also admitted.
- 0 The value of collaboration did not diminish over time.
- 0 Successful collaboration can fulfil the need for increased job satisfaction and professional development and as a result reduce staff turnover and improve staff stability.
- 0 Managers (health and education) have a role in “facilitating and providing supportive contexts within which collaboration can occur”.

Walsh (1997) argues that the differences in management structures, training and outlook between Health and Education service providers can be negotiated. He writes:

In doing so, the differences in terrain on each side must first be recognised. Recognizing, understanding and respecting their differences and their common ground could enable educators and clinicians to work together effectively in collaboration within the classroom or outside. Walsh (1997:97-98)

In conclusion, we have seen that the provision of speech and language therapy services to school age children is in most cases best described as educational provision. We have also reviewed the arguments which suggest that speech and language therapy for school age children may be best provided for in a school setting where teachers and speech and language therapists can collaborate to improve the effectiveness of the provision for the child. Collaboration is a highly desirable policy, particularly, in special education settings. However the practice of such a policy is not simple and straightforward. It needs to be supported, if the obstacles that hinder its development are to be overcome.

PROVISION FOR PUPILS IN SPECIAL SCHOOLS AND SPECIAL CLASSES

Walsh (1999:14) states that speech and language therapists from community care teams are coming under increasing pressure to provide services both to the special schools within their community care areas and to schools facilitating integration programmes in special classes. This increasing pressure must be seen in the context of the shortage of speech and language therapists generally and the prioritisation policies which have been implemented as a result. The IASLT (1993) report states that these prioritisation policies have been

“commonly used for service management, rather than clinical reasons”. It lists the “mental handicap” client group as one group which has suffered exclusion as a result. It states:

Prioritisation policies, in many cases, are effectively exclusion policies, if the group or groups given priority are so large as to require all available resources. IASLT (1993:46).

Their needs in terms of language and communication skills are clearly outlined in the Report of the Special Education Review Committee (Government of Ireland, 1993). The needs of this group are also recognised by the IASLT (1993: 22-24). It stresses that children with learning difficulties experience a wide range of communication disorders. They will require in-depth assessment by an interdisciplinary team to establish the degree and extent of communication disorder related to other areas of development. The service available to special schools and special classes will come either from the community care programme, which is very limited, or, in some cases therapy services may be available to a school which is under the patronage of a ‘Voluntary Agency’ that employs its own speech and language therapist. The IASLT (1993: 24) goes on to recommend closer liaison between Health Boards and Voluntary Agencies; development of Community Care Teams to provide a service for those with learning difficulties; development of speech and language therapy structures within the education structures to facilitate a team approach in service planning and delivery; and increased resources for this client group to address the accumulated needs following years of minimal provision.

Improving provision in this area will be a big undertaking. The SERC Report (Government of Ireland, 1993: 49-50) states that there are 114 Special Schools catering for approximately 7,600 pupils, 3,300 of these being in schools for mild general learning difficulties and 2,000 in schools for moderate general learning difficulties. Although the number of pupils attending special schools may be falling, as a result

of greater efforts to provide suitable supports in mainstream schools, the total number of children with special educational needs is not, as can be seen in the recent growth in the number of special classes catering for a variety of needs. The following table details the number of special classes in operation now as compared with 1993. The table does not include all categories of special class. The 1993 figures were taken from the SERC Report and the 2000 figures were taken from lists supplied by the Department of Education and Science.

**TABLE 1. THE NUMBER OF SPECIAL CLASSES OF VARIOUS TYPES
IN OPERATION IN 1993 AND 2000.**

Type of Special Class	1993	2000
Mild Mental Handicap	155	290
Moderate Mental Handicap	20	26
Severe/Profound	17	122
Hearing Impaired	10	15
Autism	0	60
Asperger Syndrome	0	3
Specific Learning Disability	0	20
Specific Speech and Language	9	44
Total	211	580

All of the pupils in the above categories have specific needs of varying degrees of severity in relation to speech and language therapy. The service available to most of these groups is in need of improvement in terms of quantity and in terms of the quality of the provision. One group, children with specific speech and language impairment, have access to a comprehensive school-based service if they reside within

travelling distance of one of the classes.

CHAPTER 4

LANGUAGE CLASSES / UNITS

OVERVIEW AND ADMISSIONS POLICY

The first language unit in Ireland was set up in Dublin in 1983. Nine such units were in operation by 1993 (Government of Ireland, 1993: 308). The pupil-teacher appointment ratio is currently 7:1. Teachers appointed to these posts are members of staff of the host school (Department of Education, Ireland, 1993: 94). A Department of Education list, supplied in October, 2000, shows 44 units attached to 36 primary schools. Each unit has the services of a speech therapist provided by the relevant local Health Board for about four hours per day. The admissions board structure for the units usually consists of the principal of the host school, the teacher and therapist in the unit, the principal speech and language therapist, the school inspector and the psychologist. In some units a named psychologist had responsibility for the unit. In other units the role of the psychologist varies depending on the areas the children come from. Placement in a unit is usually for a maximum of two years although this practice can vary from region to region. The criteria for admission have already been set out in the section dealing with specific language impairment.

A survey of seventeen language units carried out in 1997-1998 (Horgan 1999) found that of the currently enrolled pupils, most were attending for their first or second year in the unit. One unit had a pupil who was attending for the fourth year, eight units had some pupils who were attending for their third year. The general trend would appear to involve a two year period in the unit before reintegration. Thirteen units had eight pupils enrolled, three units had seven enrolled and one unit had nine enrolled. Boys accounted for 84% of the pupils, with girls accounting for 16%. The ages of the

pupils varied as follows: 17% were aged four or five; 46% were aged six or seven; 19% were aged eight or nine; 13% were aged ten or eleven; and 5% were aged twelve or thirteen. The average age range in an individual unit spanned four years.

The difficulties of the pupils were described as follows: 57% had a moderate or severe receptive language disorder; 77% had a moderate or severe expressive language disorder; 39% had a moderate or severe phonology difficulty; 23% had a semantic/pragmatic disorder; and 15% were described as having other difficulties such as verbal dyspraxia, cleft palate, Landau Kleffner Syndrome, hearing loss, Asperger's syndrome, auditory processing difficulties, phonological awareness problems, written language disorder, and word finding difficulties. Almost all pupils presented with multiple difficulties.

Donaldson (1995: 75-76) reports that surveys of language units in Scotland and in Britain as a whole, stress that language units vary considerably in terms of the age range they cater for; the admissions criteria they use; their relationships to mainstream schools; and the nature of their staffing. Donaldson (1995: 80) cites a Scottish survey which presents the views of language unit staff on the advantages that language units offer. These were:

- 0 a high staff ratio enabling individual and small group teaching;
- 0 understanding of the children's needs – a supportive environment;
- 0 a curriculum geared to developing language and communication;
- 0 speech therapy provision.

AFASIC (1995) describe the language unit setting as follows:

Here children follow as nearly as possible the national curriculum, but the teaching concentrates on language and communication skills. Intensive speech and language therapy should be available. Units are placed within mainstream schools to allow for integration with the rest of the school when appropriate – for some lessons or during lunch-times, for example. A child will generally need a Statement of Special Educational Need to be admitted to a unit. Units vary considerably, and have different admission policies. Some units encourage more integration than others and the level and intensity of speech and language therapy varies according to health authority funding and local education authority policies. A unit might be a single class or sometimes more. AFASIC (1995:4-5).

The Royal College of Speech and Language Therapists (1996) sets out the aims/principles for service delivery in this setting as follows:

1. To provide a service which involves a high degree of shared knowledge, skills expertise and information among those involved with the child.
2. To provide speech and language support, assessment and intervention for the child attending the unit as an integral part of school life.
3. To recognise that primacy of care is with the education authority for the holistic management of the child's speech and language difficulties.
4. To implement working practices that accommodate all the needs of the child, in addition to those needs specifically identified by the speech and language therapist's assessment.

5. To acknowledge that educational placement in a language unit recognises that the child's speech and language difficulties have implications for his/her education, and that a positive statement is being made about the child's overall needs being intrinsic to his/her speech and language needs.
6. To deliver the service in such a way as to work with education staff, incorporating the aims of the speech and language therapy programme in the planning of the language programme. The Royal College of Speech and Language Therapists (1996:61).

The two main organisations in the UK who promote the provision of facilities for children with communication difficulties – AFASIC and Invalid Children's Aid Nationwide (ICAN) – have both published guidelines for Primary School Units for speech and language disorders. AFASIC (1988) cite the following criteria for entry to a language unit:

- 0 evidence of specific speech and/or language disorder with evidence of average non-verbal potential, considerably greater than verbal ability;
- 0 some evidence of willingness to communicate;
- 0 the language disorder is not the outcome of severe physical handicap;
- 0 evidence of difficulty in the child's first language if this is not English;
- 0 no evidence of severe hearing loss, organic or primary emotional disorder;
- 0 if in doubt a provisional one-term placement should be made;

- 0 children whose difficulties stem from environmental conditions should be catered for in mainstream classes;
- 0 priority should be given to the 3 to 7 year olds if places are limited.

Other recommendations include the following:

- 0 language unit children should be allowed opportunities to integrate with an appropriate peer group for specific purposes in a planned and monitored fashion;
- 0 integration should be flexible and geared to the individual needs of the child; for some it may not be appropriate;
- 0 the pupils should be helped to develop social and life skills;
- 0 the host school principal and staff should be supportive of the language unit concept especially in the area of integration;
- 0 the unit should be self-contained, with a separate quiet room for individual therapy etc., but should not be isolated from the rest of the school;
- 0 full-time training courses, leading to a nationally recognised qualification, should be organised by universities that run Speech Therapy/Linguistics courses with short courses to supplement the longer intensive ones;
- 0 multidisciplinary training courses are essential;
- 0 each group of eight children should have one teacher, one therapist, one non-teaching assistant and the services of a named educational psychologist at least four times each term.

The ICAN (1988) guidelines are broadly similar. They go into greater detail on the different forms of specific language impairment and on the need to have a manageable mix of children to work with. They call for regular non-contact time for teachers and therapists to undertake a range of non-teaching tasks and they set out a list of duties for language unit staff. The Department of Education (Government of Ireland 1993: 91-96) guidelines on language units, generally comply with the AFASIC/ICAN guidelines as set out above.

CURRICULUM GUIDELINES

Guidelines for language units in Irish primary schools (Government of Ireland, 1993: 93) state that pupils with specific speech and language disorders need small classes with a curriculum which is taught through the medium of the language of the home and which does not include a second language. The curriculum should be similar to that followed by their peers in mainstream classes but with a constant emphasis on the language involved in each subject area. A structured language programme, intensive speech therapy and opportunities for interacting with other pupils in ordinary classes should be provided.

In the United Kingdom HM Inspectors of Schools (1996: 22- 32) offer their opinions on what constitutes good practice in the areas of curriculum, teaching and learning, based on the evidence of a four year period of school inspection of provision for language impaired pupils in a variety of school settings. Their main conclusions were as follows:

- 0 National curriculum guidelines should provide the curriculum framework for language units. A broad curriculum consisting of English language, mathematics, environmental studies, expressive arts, and religious and moral education should be provided.

- 0 Individualised educational programmes (IEPs) based on multi-professional assessments should be developed for each pupil but also integrated with the curriculum for the class.
- 0 The writing attainments of pupils were specifically highlighted as being in need of improvement.

The difficulty in meeting the various guidelines detailed above is acknowledged by Cranmer (1992: 3). He calls into question the acceptability of a situation in which one teacher has to deliver the full curriculum range across more than one curriculum stage to a small group of pupils who differ in age, ability and severity of speech and language problems.

Lees and Urwin (1997: 140-163) stress the areas of attention and listening work, verbal comprehension, concepts and vocabulary, word finding strategies, organising information, developing expressive language, and the social use of language in their review of provision for children with speech and language difficulties in primary schools.

In its 'Principles for Educational Provision' AFASIC/ICAN (1996) lay particular stress on addressing the issues of social skills strategies and self-esteem when considering the curriculum for language impaired children. MacDonald (1994) makes the need for this clear when she writes:

... the language-impaired child will face further social difficulties due to the impact of communication dysfunction on social functioning... Children whose communication competence is poor are among the most vulnerable in a social order where chat, planning, scheming, joking and gossiping are valued skills. MacDonald (1994:24).

It is clear that teaching language impaired children requires particular skills in delivering a carefully structured, individually based curriculum which caters for their intellectual, linguistic and social needs. It reiterates the need for a high skill level on the part of adults helping children with language difficulties and points to the need for specialist training of teachers working in language units. In planning a curriculum with reference to speech and language difficulties there is also a need for collaboration between teachers and therapists. Fleming et al. (1997: 15-16) suggest it is in these activities that they can most effectively collaborate and learn from each other.

INTEGRATION AND REINTEGRATION.

An important feature of language unit provision is that it is viewed as a relatively short-term measure with the aim of reintegration into a mainstream setting for the vast majority of language unit pupils. This raises two important issues; that of integration with mainstream classes in the host school while the children are pupils in the language class, and the reintegration of the children into their own local schools when they are discharged from the language unit. The Department of Education, Ireland, (1993: 93-96) guidelines specifically state that language unit pupils should participate in ordinary classes in the host school for some activities, as appropriate, in each case. These guidelines also acknowledge that, on reintegration into mainstream classes, most of these pupils will continue to have residual difficulties.

In Scotland HM Inspectors of Schools (1996: 35-37) state that the nature, degree and quality of integration in language units varied markedly.

The advantages of integration were that it:

- 0 provided pupils with language and communication disorders with typical classroom environments where they could learn and interact with others who provided models of appropriate behaviour and peer language;

- 0 helped the pupils to learn in settings where there was less dependence on adults than would be found in special provision;
- 0 enabled pupils' progress to be monitored and reviewed in the type of setting to which it was hoped that the majority would return on a full-time basis;
- 0 ensured that the staff in language units remained in touch with the mainstream curriculum and were thus in a position to adapt it for pupils in the unit; and
- 0 helped mainstream teachers to remain aware of the continuum of needs related to pupils with language and communication disorders. HM Inspectors of Schools (1996:36-37).

Conti-Ramsden and Adams (1995) review the limited number of studies on the integration of children with SLI. In their review of both UK and North American studies they found that only a minority of children integrated from special to mainstream provision were able to make satisfactory progress. Most SLI children appear to have persistent disabilities through their school years. In particular, they note that children with SLI had a marked dependence on the class teacher, and, although they talked to their non-SLI peers, their peers did not initiate talk with them. They conclude that "children with SLI have grave social difficulties in ordinary classes and that the process of their integration needs to be analysed and monitored in detail". Conti-Ramsden and Adams (1995:8).

PROFESSIONAL DEVELOPMENT NEEDS OF LANGUAGE CLASS TEACHERS AND THERAPISTS

Introduction

Lacey and Lomas (1993: 1) make it clear that adopting an integrated

approach to pupils with special needs is not just a matter of putting different professionals together and leaving them to it. Staff they argue need “both time and training to make the most of each other’s skills and expertise”.

Kersner (1996) also makes a very explicit link between the need for both teachers and therapists to acquire knowledge and awareness of each other’s areas of expertise and the need for effective collaboration. She writes:

It would certainly seem that professionals work best together when they have a shared language and a shared understanding of each other’s work, and that this is more likely to lead to a collaborative rather than an expert model of working... Professional development opportunities must be created for teachers and therapists to be specifically trained regarding the needs of the client group and to be able to understand each other’s practice so that they can communicate and collaborate more effectively. Kersner (1996: 26).

It is clear that the professional development needs of teachers and speech and language therapists have to be met if collaborative work is to be successful.

Teachers

In keeping with the recommendations of the SERC Report (Government of Ireland 1993) professional development courses should be on an academic footing leading to the award of a recognised qualification. Courses must be accessible to all the teachers involved regardless of the geographic location of the language class. The following points need to be considered:

- 0 The suitability of the present Special Education Diploma Courses in terms of their relevance to the work of the language class teacher. A modification of this type of course with a greater proportion of time devoted to language class issues could be considered. Such a course, or a completely new course, would have to be devised in collaboration with various bodies such as the Colleges of Education, School of Clinical Speech and Language Studies, INTO, IASLT, Special Ed. Section of DES.
- 0 The mode of delivery of such a course would have to be considered in the light of the requirement of accessibility. The provision of a part-time, regionally-based distance education course should be considered. Such a course could be modular in nature with a recognised award on completion of all modules.
- 0 The possibility of an element of joint attendance by teachers and speech and language therapists has to be considered.
- 0 Courses should assist teachers in the following areas:
 - 1. They should be able to make observations which reflect knowledge and understanding of the processes of communication and language within the overall development of children.
 - 2. They should be able to recognise the nature of communication and language difficulties and their effect on children's learning.
 - 3. They should be able to plan, implement and evaluate the curriculum taking into account the needs of children with communication and language difficulties.

4. They should be able to participate in and evaluate interprofessional intervention with children with communication and language difficulties.
5. They should be able to reflect on their own spoken and written communication skills with children and their parents and with colleagues.
6. They should be able to reflect on their own teaching practice and describe any changes that they have made as a result of their study.

(Miller and Wright 1995)

- 0 A national forum of teachers, speech and language therapists and other professionals involved with language classes should be considered. Such a forum could facilitate a regional structure to support language classes.
- 0 The need for specific time for teacher/therapist liaison needs to be addressed. This needs to be done in the context of a review of the therapy hours provided to language classes. At present most classes do not have a therapist for the full school day.

Principal Teachers

In-service specific to principals could be organised as a module of the overall programme for teachers. Such a module could include areas such as:

- 0 an overview of specific language impairment;
- 0 collaborative working with Health Board Professionals;
- 0 defining areas of responsibility;
- 0 managing the 'deployment' of a SLT in the school;
- 0 enrolment policy for the language class;

- 0 admission and discharge procedures;
- 0 integration of pupils in mainstream classes;
- 0 the process of re-integration to local schools;
- 0 parental contact.

Speech and Language Therapists

- 0 change in work practices and modes of service delivery which language class placement facilitates;
- 0 collaborative working with language class teachers and mainstream teachers;
- 0 school curriculum;
- 0 classroom management;
- 0 information on school policies and school terminology;
- 0 time for liaison with the language class teacher and liaison with other language classes;
- 0 developing a shared knowledge base with teachers.

Clarification of the Teaching and Therapy Roles

In recent years the role of the SLT has evolved from an expert or specialist model to a 'collaborative-consultative' model. This model has been described by Reed (1992) as "an interactive process that enables teams of people with diverse expertise to generate creative solutions to mutually defined problems". This poses a challenge to the traditional situation where the therapist, working from a medical model, would assess, plan and implement programmes for individual children with a specific focus on language. In contrast, teachers, working from an educational model, manage class groups in the delivery of the whole curriculum. Collaborative work will require a willingness from all to modify their traditional working practices.

There is scope to explore the stages in a move towards a transdisciplinary model of working as outlined by Woodruff and McGonigel (1988):

- 0 **role extension:** team members increase their knowledge in their own area;
- 0 **role enrichment:** team members increase their knowledge in the other's area;
- 0 **role expansion/exchange:** team members share information directly re assessment and teaching strategies etc;
- 0 **role release:** team members take on each other's roles in an instructional setting;
- 0 **role support:** team members assist each other as they guide a student through the learning process.

Walsh (1997) argues that a collaborative approach involves an attitude of sharing, teaching and learning across traditional professional boundaries with an emphasis on discussion, cooperation, sharing of knowledge and skills, and interdependence; rather than individual professionals providing special programmes in isolation. This is dependent on appropriate professional development for teachers and therapists, adequate time for planning and evaluation, and clear overall guidelines on the operation of language classes.

Conclusion

McCartney and Van der Gaag (1996: 318) link the issue of speech and language therapists working in educational settings with collaborative work by teachers and therapists, and professional development of teachers.

Therapists and teachers increasingly recognise that the traditional one-to-one intervention model used by therapists in schools does not maximize the

child's communication potential. It does not promote carryover of new skills, nor does it allow for teachers and therapists to establish joint aims and objectives for the child. Increasingly, examples can be found in school settings where teachers undertake further training in order to develop specialist knowledge on language and communication and therapists work almost exclusively alongside teachers in the classroom.

BECTON (1998)

CHAPTER 5

RECENT IRISH RESEARCH FINDINGS

In this chapter four research reports will be briefly reviewed. The first two, written by speech and language therapists, deal with the provision of speech and language therapy to children generally. The other two reports deal more specifically with the operation of language classes.

In '**A study of Irish primary teachers' awareness of pupils with speech and language difficulties**', Becton (1998), in a survey of ten urban primary schools, set out to:

1. Investigate mainstream primary school teachers' awareness of pupils in their classroom who presented with speech and language difficulties.
2. Investigate which types of collaborative practices, if any, were being used by the teachers and therapists involved.
3. Look at ways of improving collaborative practice.

From her research Becton concluded that while many teachers appear to have a good understanding of speech, language and communication difficulties, many teachers will neither have referred a pupil for speech and language therapy, nor will they have had contact with a speech and language therapist. She found, as expected, that no inclusive collaborative practices were taking place, but that some tentative arrangements between teachers and therapists were in place. Contact was most likely in the form of the therapist's report, guidelines for work or a phone call. In a number of cases the therapist had visited the teachers. Becton concludes that there is evidence of the

beginnings of collaboration but that the process is considerably less well developed than in other countries. She cites the lack of official recognition of the educational role of the speech and language therapist as a possible significant factor in the development of the process. Specific findings included the following:

- 0 Thirty-one percent of respondents had made a referral to a speech and language therapist.
- 0 Twenty-three percent of class teachers were aware of pupils in their class that were receiving speech and language therapy.
- 0 Thirty percent of respondents replied that they had contact with a speech and language therapist about a pupil in their class.
- 0 Almost half of the class teachers felt that there were pupils in their class who presented with communication difficulties but were not receiving therapy. All the principal teachers and seven out of nine remedial teachers responded similarly.
- 0 Only twenty-four percent of respondents reported that they had received any type of training with regard to speech and language difficulties. This training was most likely to have been a part of initial teacher training or of

WALSH (1999)

the Remedial Teachers' Diploma Course. Almost no in-service training was reported.

- 0 Eighty-one percent of respondents felt that it was very important to have contact with a speech and language therapist who was working with pupils in their class.

- 0 Under 'further comments' respondents raised the issues of the need for therapists to be available as part of a continuum of support services for schools, the importance of contact with the therapist, the poor quality of what is presently available and the need for further training for teachers in the area of speech and language difficulties.
- 0 Some of the areas identified as important for further training were: input on the role of the therapist; information on how to identify speech and/or language difficulties; information on when to refer children for speech and language therapy; and guidelines for fostering the development of communication skills in the classroom.

Becton outlines action which could be taken by teachers, therapists, and their employers. Among her suggestions are the following:

- 0 Teachers and therapists already engaged in collaboration should document their work; designate specific time for liaison; provide information on their respective roles, policies and terminology; and evaluate current models of service delivery.
- 0 Therapists who are working in educational settings should be supported by their Head of Department in any measures they undertake to develop collaborative working practices with their colleagues in education.
- 0 Teachers could request input from their local speech therapy service on relevant aspects of working with children with speech and language difficulties. They could also ask for the referral criteria operated by the local speech therapy service. They could find out if the INTO has developed a policy on collaborative or inclusive practices and share this information with their therapist colleagues.
- 0 Health and education employers should support staff in

providing a holistic or inclusive approach to meeting the needs of children who are their clients.

- 0 Teachers and therapists who already work together need to consider their joint training needs. They also need to consider separately what training they can provide for their partners and what assistance and resources they need from their employers in this regard.
- 0 Teachers and therapists should consider various models of collaboration which may better meet the needs of children with communication difficulties who are increasingly being educated in mainstream settings. They should become aware of the potential barriers to collaboration and accept that it is an approach which may take years to become fully established.
- 0 Teachers and therapists should bring the resource implications of collaborative practices to the attention of their managers and the organisations to which they are

HORGAN (1999)

affiliated.

Becton concludes:

It would appear from the research that there is a lot of scope for speech and language therapists to work more closely with primary school teachers, in spite of the systems in operation which ensure that health and educational professionals rarely have occasion to meet in mainstream settings. Becton (1998:76).

In 'A Review of Policy and Adequacy of Speech and Language Therapy Services in Ireland with Particular Reference to Services for Children', Walsh interviewed the teachers in an urban primary

school for disadvantaged pupils. She found that although the teachers had a very high awareness of speech, language and communication disorders there was a lot of confusion in relation to the role of the speech and language therapist in dealing with communication disorders. This confusion was related to their perception of prioritisations within that role given present service constraints. Confusion was also expressed about criteria for referral and there was frustration with waiting time for assessment and therapy. All the teachers interviewed perceived the present service delivery model (clinic-based with significant waiting lists) as being inadequate at meeting the needs of the students in the school. All the teachers perceived their training in speech, language and communication disorders as being inadequate. In general, a relatively high level of therapist-teacher contact was reported. This contact tended to be in the form of written reports and guidelines with phone contact and in-class pre-scheduled meetings taking place regarding students with severe problems.

Before considering solutions to improve the current situation, Walsh outlines some constraints that need to be taken into account. These are:

- 0 There are only 277 whole-time equivalent speech and language therapy posts in the country for all child and adult services. There are 44,273 primary and post-primary teachers.
- 0 Speech and language therapists liaise with a very wide range of professionals other than teachers in the course of their work.
- 0 There is a very high incidence/prevalence rate of communication disorders, many of them requiring very labour-intensive direct and indirect SLT involvement.
- 0 Until the recent Education Act 1998, there has been a lack of formal recognition of speech and language therapy services by the Department of Education and Science. The

implications of the Act for the future organisation of SLT services for students has yet to be formally discussed.

- 0 In countries that have relatively well-developed collaborative practices (eg: Scotland) there is a much higher ratio of SLTs per 100,000 population.

Walsh makes the following recommendations as a result of her study:

1. That a large-scale state sponsored Evaluation Research Study be undertaken to examine present SLT services and collaborative working practices in dealing with primary level students presenting with communication disorders. This study would look at primary school services in mainstream schools; special schools for students with general learning difficulties, social and emotional difficulties or challenging behaviour; special classes; and schools in disadvantaged areas.
2. To set up a Department of Speech and Language Therapy, comprised of a group of experienced SLTs with a minimum of five years working with children and experience in liaison with teachers, within the Department of Education. This department would maintain strong links with SLT departments in Health who would continue to be the main service providers. The aims of this department should be:
 - 0 Organisation of training and workshops for teachers with a long term aim of joint training workshops to facilitate the development of collaborative practices.
 - 0 The development of other information networks regarding communication disorders and classroom management strategies.
 - 0 Involvement in the medium to long term in curricular development.

- 0 In conjunction with Health Board SLT departments, involvement in a range of local pilot projects. This would involve the development of various models of school-based services eg: outreach consultancy models, intensive programmes within certain schools etc.
3. A forum to be set up as soon as possible, comprised of speech and language therapists, teachers, parents, representatives from Health and Education and at least one TD. This would be a practical way to address recommendations 1 and 2.

Recently two Pilot programmes in Disadvantaged Areas have been set up. In these a speech and language therapist works in a school on a class basis providing a language enrichment programme in collaboration with the class teachers.

In **'Language Units in Irish Primary Schools'** Horgan (1999) surveyed the teachers and speech and language therapists in twenty-four language classes.

ADMISSIONS CRITERIA

There was general satisfaction with the important issue of criteria for admission to the language class. However, a majority of teacher/therapist pairs offered suggestions for improvements in this area. The need for the language class teacher and speech and language therapist to meet, observe and test the children before admission to the class. Otherwise decisions can be solely based on the written reports of others.

- 0 The psychologist attached to the language class to make a psychological report on all the candidates for admission.

- 0 Admissions criteria to deal with the issue of co-existing problems such as physical abnormality, Asperger's Syndrome, and behavioural problems.
- 0 There is a lack of clarity in the definition of SLI in the area of the child's relative verbal/non-verbal abilities.
- 0 Some respondents called for more standardised criteria and stricter adherence to the criteria for admission. Other respondents argued that a degree of flexibility is required and that on occasion professional judgement and mutual trust may indicate that certain criteria should be overridden.
- 0 The criteria should be used to explain to parents the reasons for their child's admittance or non-admittance and should be used to draw up a contract between staff and parents about their respective roles and responsibilities.

PSYCHOLOGICAL SERVICE

In contrast to the issue of admissions criteria, the question of a psychological service for language classes evoked high levels of dissatisfaction among respondents. This was an area which was seen to be in much need of improvement. The lack of uniformity in the provision of such services was one of the clearest findings in this area of the study. The following suggestions were made.

- 0 A specific psychologist should be attached to the language class and should carry out assessments and reviews as necessary. This would eliminate the lack of consistency between reports from different psychologists.
- 0 Sufficient time should be allotted to the psychologist to carry out language class related work and to have regular contact with the language class.
- 0 An educational psychology service rather than, or in addition to, a clinical psychology service should be

provided.

- 0 The psychologist should work more as part of the language class team rather than as an outside professional.
- 0 The psychologist should spend more time with the pupils in the class and advise on such issues as reintegration, behaviour management, emotional difficulties, self-esteem, parental counselling, attention deficit disorder, hyperactivity, perceptual difficulties, and pragmatic difficulties.

INTEGRATION

The survey results on the issue of integration of language class pupils with mainstream classes showed that this is a problematic area for language classes and not as straightforward for either pupils or teachers as may first appear. There was a correlation between the amount of time spent by language class pupils integrated with mainstream classes and the amount of time worked by the therapist in the language class. There was also a correlation with the amount of time spent by teacher/therapist pairs in joint work. In both cases higher levels of integration were associated with proportionately less time spent by the therapist in the class and with less time spent on joint work. It would appear to highlight the complex nature of the interactions between language class teacher, language class speech and language therapist, mainstream class teacher and language class pupil. It may also suggest that integration policy is not so much directed by educational considerations as by practical organisational concerns.

Suggestions for improvement included:

- 0 There should be a school policy on integration agreed prior to the establishment of new language classes.
- 0 The issue of integration should be addressed in the School Plan and should not be solely dependent on the goodwill of teachers.
- 0 There is a need to evaluate the effectiveness and efficiency of integration to ensure that it is more than just integration in name. Regular feedback from the class teacher to the language class staff should be organised.
- 0 There should be a facility for language class staff to observe language class pupils during integration with a mainstream class.
- 0 Numbers in mainstream classes should be reduced to facilitate the integration of pupils. Other supports such as the training of teachers and the availability of classroom assistants should also be provided.
- 0 Where appropriate, integration should be extended to cover a wider range of school subjects.
- 0 The burden on the child to integrate in a strange school setting should be acknowledged. Daily integration may be disruptive and unsuccessful and may need to be put off until the child is approaching the end of his term in the language class. Then it should be organised for longer periods of time each day, even for full school days.

RE-INTEGRATION

On the important issue of reintegration of pupils back to their local schools following discharge from the language class a high level of dissatisfaction was expressed by the respondents. Like the area of

psychological services it was seen as an area in need of a much greater investment in resources. It also highlighted the issue of the long-term nature of the difficulties faced by language disordered children. The respondents outlined improvements they would like to make in this area:

- 0 Almost all the respondents referred to the need for time and resources to be made available to allow for contact between the language class and the schools receiving the language class pupils. This contact could take place both before the child leaves the language class and following the child's reintegration.
- 0 The role of the psychologist in this area was mentioned by three classes.
- 0 Follow-up supports such as continuing speech and language therapy, the availability of a remedial teacher and/or classroom assistant in the receiving school, and a support system for mainstream teachers and the parents of the pupils were mentioned by a number of classes.
- 0 Some respondents referred to the need to develop a protocol, standards, or guidelines to inform practice in this area.
- 0 A number of respondents referred to the need to make additional training available to mainstream teachers in the area of language disorders.
- 0 One language class suggested that a liaison teacher be used to facilitate re-entry to mainstream school for language class pupils.

POSITIVE AND NEGATIVE FEATURES

For teachers the main positive feature of work in the language class was individual work with a small number of pupils. For therapists the main positive feature was daily contact with pupils in a holistic, intensive, naturalistic setting. For both groups the second positive feature was working with another professional in the class. For teachers the main negative feature of work in the language class was the difficulty in managing a range of age groups and covering an over-loaded curriculum within a short time in an intensive set-up. For therapists the main negative features were less face to face contact with parents, the intensive nature of the work, lack of time when other Health Board work had to be undertaken, and less contact with other therapists.

SPEECH AND LANGUAGE THERAPIST IN A SCHOOL SETTING

There was strong agreement from both teachers (82%) and therapists (91%) that therapists working with school-aged children should be employed by the Department of Education. There was no uniformity between classes in relation to the number of hours worked by the therapist each week. A majority of therapists felt that the time for language class duties was not sufficient. If more time were available the therapists responded by stating that they would use this time for collaborative work with teachers, parents, and other professionals. The issue of time spent by therapists in language class work and time in clinic work was found to have a significant correlation with collaborative work and pupil integration. A majority of therapists (82%) felt that their views on service delivery to school-aged pupils had changed as a result of their experience in the language class. A combination of the school and clinic was chosen by 45% of therapists as their first choice of work setting, 36% chose the school and 14% the clinic.

PROFESSIONAL DEVELOPMENT

Over ninety percent of teachers and therapists were dissatisfied with the procedures in place for induction. For both teachers and therapists the most often cited activity which assisted them in settling in to their role in the language class was interaction with their partner. There was a clear consensus among teachers and therapists of the need for additional inservice training relevant to their work in language classes. No teacher held an additional qualification in the area of specific language impairment. Half of the teachers had attended a one-week induction course. All but two of the teachers agreed that a specific qualification should be available to language class teachers. There was a clear preference expressed for such qualifications to be available through part-time courses using distance education techniques.

COLLABORATION

Consultation between teachers and therapists in language classes generally takes place informally. There is a recognition of the value of

INTO (1999, UNPUBLISHED)

more formalised ways of undertaking such consultation. Teachers and therapists have a positive view of their working relationship, but they also recognise that it is an area where there is scope for further development. The survey probed the nature of the collaborative work undertaken by teachers and therapists. Multidisciplinary, interdisciplinary and transdisciplinary models were explored. They are described below:

A multi-disciplinary approach.

We work on developing the best possible plans in our own area of expertise so

that the pupils will benefit from the best practice in education and in speech and language therapy.

The teacher and speech and language therapist conduct their own separate pupil assessments.

The teacher and speech and language therapist each develop a plan for their own area of expertise.

The teacher and speech and language therapist implement the part of the plan related to their own area of expertise.

The teacher and speech and language therapist recognise the importance of each others' contributions and professional expertise in providing a service for the pupils.

An inter-disciplinary approach.

We work together to evaluate individual needs and to develop intervention plans for the pupils. We coordinate our respective skills and expertise to provide the best service for pupils.

The teacher and speech and language therapist share information from their separate assessments.

The teacher and speech and language therapist share their separate plans with one another.

The teacher and speech and language therapist implement their own section of the plan and incorporate sections from the other's plan where possible.

The teacher and speech and language therapist are willing to develop, share, and be responsible for providing services that are a part of the total service plan.

A trans-disciplinary approach

We work closely with each other sharing skills and information across professional boundaries leading to the expansion and interchange of our roles.

The teacher and speech and language therapist conduct a comprehensive assessment together.

The teacher and speech and language therapist develop a plan together to meet the needs of pupils.

The teacher and speech and language therapist implement the plan with minimum regard for boundaries of expertise.

The teacher and speech and language therapist are willing to develop, share, and be responsible for providing services that are a part of the total service plan.

There was agreement between teachers and therapists that they viewed themselves as working in an interdisciplinary fashion. Both groups also looked on a move towards a more transdisciplinary way of working as being desirable. Both groups expressed a desire for further development of their professional relationship. The interdisciplinary approach was the most often chosen approach when teacher/therapist pairs were asked to describe their present way of working. The amount of joint work carried out by teachers and therapists on a day to day basis varied.

The number of language class hours worked by the therapist as a percentage of the total working week – was the factor which was most closely correlated ($r = 0.621$) with the amount of time spent in joint working.

PRIORITIES FOR FURTHER DEVELOPMENT

When teachers and speech and language therapists were asked to outline priorities for further development of the language class service, there was general agreement between both groups. They are listed below in order of priority.

1. In-service and professional development issues including joint working, research, and liaison with other classes.
2. More provision of language classes at all levels from pre-school to second level.

3. Departments of Education and Health support.
4. Better psychological and other support services.
5. Improved re-integration procedures.
5. Language class curriculum and class organisation.
6. Integration with mainstream classes.
7. Collaboration between teachers and therapists.

The main conclusions from his research were as follows:

- 0 the experience to date strongly indicates that the type of provision presently available in existing language classes should be expanded so that language impaired pupils of all ages and in all locations are provided with an adequate school-based service;
- 0 the provision of psychological and other support services to language classes should be improved as a matter of urgency;
- 0 major policy areas in the operation of language classes, such as admissions criteria, integration with mainstream classes, parental involvement, and support for pupils being reintegrated into mainstream schools need to be subjected to a national review in the light of experiences to date;
- 0 most importantly, there needs to be a major initiative, supported by health and education managements, in the area of providing for the professional development needs of teachers and therapists working in language classes;
- 0 central to any professional development initiative should be the establishment of a national forum for staff engaged with pupils in language classes;
- 0 the dedication and expertise of teachers working in

- language classes needs to be recognised and further underpinned by the establishment of accredited award-bearing post-graduate courses run in a manner which would facilitate participation by all interested teachers;
- 0 the development of curriculum resources, classroom management strategies, and collaborative practices should form a major part of any inservice provision;
 - 0 speech and language therapists should be employed to work in language classes for full school days so as to facilitate a collaborative working style, integrate therapy programmes more fully with the school curriculum, support integration and reintegration initiatives, undertake joint research activities with teachers, and have an input into relevant school and curricular issues;
 - 0 speech and language therapists working in language classes should not be expected to undertake onerous clinic-based work but should be facilitated in maintaining professional contacts with fellow therapists and other health professionals;
 - 0 in the long run consideration should be given to the establishment of a speech and language therapy service within the Department of Education dedicated to serving the needs of all school-aged children in a collaborative classroom-based manner.

In October 1999, the Irish National Teachers' Organisation surveyed the **Principals and Teachers in the Special Classes for Speech and Language Disorder**. The Survey was sent to all schools with a Class for Speech and Language Disorder which numbered twenty eight at that time. Twenty schools responded and a summary of their concerns is described below.

NUMBERS OF CHILDREN IN NEED OF THERAPY.

The replies indicated that there is a ``serious shortage of speech and language therapy for primary school children. There was also a shortage of places in special classes for speech and language disorder. The responses also indicated that there is considerable variation among Health Board regions in the amount of time allocated to Speech and Language Therapists in these classes. Respondents indicated that the speech and language therapist should be assigned to the class for the full school day, so that working with children and planning and discussion with the class teacher can also occur. In some cases the classes were operating without the support of a speech and language therapist.

REFERRAL PROCEDURES

All respondents indicated that referral procedures to the special class for speech and language disorder are currently controlled by the Health Board. The majority of respondents indicated dissatisfaction with this practice and consider that the school should be central to the referral process. Among the complaints made were that teachers were not given adequate time to consider reports prior to admissions meetings and that the usefulness of the reports themselves was questionable. The majority of respondents called for more standardised criteria for admission, whereas others indicated that a degree of flexibility is required. Concern was also expressed around the absence of a core team at all stages of the management of speech and language disorder from referral to discharge. Comments in relation to referral indicate that there is a need for

- 0 Clarification of roles between Health and Education.
- 0 Standardisation of the referral system nationwide.
- 0 Language class teacher and therapist to meet, observe, and test the children before admission to the class. Otherwise decisions can be made solely on the written

reports of others.

- 0 The Department of Education and Science should develop a Speech and Language Unit with a pool of speech and language therapists similar to the proposed national psychological service and working in tandem with the psychological service.
- 0 An educational psychology service in addition to a clinical psychology service should be provided with a specific psychologist attached to the language class to carry out assessments and reviews where necessary. This would eliminate the lack of consistency between reports from different psychologists.

SUPPORT SERVICES

The psychological service was deemed to be inadequate at present. Input is required on an ongoing basis to deal with social and emotional problems which are secondary to the language impairment and to provide counselling for parents in this regard. A majority of respondents also indicated that the provision of Classroom Assistants to the language classes would be very helpful given the particular needs of children with speech and language impairment. Concern was also expressed that some of the children who attend the speech and language classes return to mainstream education without adequate back-up services.

PROFESSIONAL DEVELOPMENT

All respondents indicated the need for professional development not only for the teachers in the language classes but also for principals and other teachers working in the school. Newly appointed teachers to language classes have particular professional development needs

as the teaching and management of children with speech and language impairment is very different from teaching in the mainstream. Induction is needed both in relation to language disorder and collaborative working with a speech and language therapist. Visits to other language classes should be facilitated by the Department of Education, as should the funding and provision of courses and the provision of substitute cover. It was also suggested that the Department of Education should facilitate the founding of an association for teachers working in language classes. This association could organise conferences and seminars and publish a newsletter. The need for joint courses for both professionals working in language classes was also identified. It was also suggested that the Diploma in Special Education should be made more widely available in centres outside Dublin and also on a distance education basis.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

SPEECH AND LANGUAGE THERAPY SERVICES FOR CHILDREN

- 0 The INTO calls for an examination of the current levels of provision for school-aged children and for a co-ordinated response from the Departments of Health and Education to the current shortfalls in provision.
- 0 The Department of Education and Science should develop a speech and language unit with a pool of speech and language therapists similar to the proposed national psychological service and working in tandem with the psychological service.
- 0 A consultancy model of service delivery should be developed whereby the teacher and the speech and language therapist meet to agree on classroom activities that will support the work that is done with the pupils in the clinic.
- 0 Procedures throughout the Health Board regions, should be standardised to enable teachers to refer children (with parental consent) to speech and language therapy services.

LANGUAGE CLASS ADMISSIONS

The INTO recommends that:

Criteria for referral, assessment and admission procedures should be agreed between schools and Health Boards with recognition of the roles

of both agencies. These criteria should be standardised throughout the country. The School should be central to the referral process. The standardised procedures should deal specifically with such issues as:

- 0 compilation of reports for admissions meetings and protocol for forwarding reports to the school principal;
- 0 reports to be with all members of the Admissions Committee by a specified date prior to the meeting;
- 0 criteria for prioritisation;
- 0 short-listing of candidates and notification to parents;
- 0 provision for the teacher and speech and language therapist to meet and observe each child, by visiting the child in class or by inviting the child to the language class;
- 0 the provision of an information booklet for parents which addresses eligibility, the process of selection, review and discharge procedures, the function of the language class and parental involvement;
- 0 notification by the school principal/principal speech and language therapist of parents of the children accepted or not accepted for the language class, and
- 0 following the admission's meeting the parents and child be given an opportunity to visit the language class, a contract to be prepared for parents so that they understand the nature and terms of the provision being offered.

ASSESSMENT PROCEDURES AND REVIEW

The INTO recommends that:

Guidelines should be established to clarify the areas in which the teacher and the speech and language therapist assess and report to parents/ other professionals. Procedures regarding assessment should

be organised on a school basis, with recognition of the joint role of the teacher and the speech and language therapist. These procedures should take account of:

- 0 the need for initial assessments to be carried out early during the first term;
- 0 joint programme planning;
- 0 termly meetings with parents;
- 0 review of placement at the end of year one;
- 0 contact and support for mainstream schools where a pupil is being discharged;
- 0 and a protocol for reaching agreed decisions on the desirability of discharge.

PSYCHOLOGICAL REVIEWS AND ROLE OF THE PSYCHOLOGIST

The INTO recommends that:

Procedures regarding psychological reviews should be standardised. The roles of the psychologist and the school principal in relation to the psychological review should also be clarified. In particular the following points should be addressed:

- 0 the school should seek parental consent for reviews at the beginning of the school year;
- 0 the teacher and speech and language therapist should jointly prioritise the children in need of a psychological review;
- 0 parents and school principal should be notified by the psychologist in advance of a psychological review;
- 0 the school principal should receive a copy of the psychological report of all children attending the

- language class within a reasonable time frame;
- 0 in the interest of confidentiality, communication with psychologists should be conducted formally by school principal and the principal speech and language therapist;
- 0 following standardised guidelines, the school principal should meet with the psychologist to establish procedures for reviews and to clarify what a psychological review can offer;
- 0 the DES should clarify the position regarding retention of a child, in the class where psychological assessment results are borderline or not definitive, prior to entry to the language class and also when assessed a year later;
- 0 in the circumstance that the psychological review on a standardised test of intelligence indicates the non-verbal performance is not in the average range, it is proposed that the psychologist should make parents aware of the educational implications of additional/alternative support provision where this is suggested;
- 0 the DES should employ more educational psychologists to have special responsibility for the speech and language classes, so that a specific psychologist can be attached to the language class to carry out assessments and reviews as necessary;
- 0 additional psychologists are also required on an ongoing basis to deal with social and emotional problems which are secondary to language disorders. Counselling for parents is also essential in this regard.

TEACHER / SPEECH AND LANGUAGE THERAPIST / PRINCIPAL RELATIONSHIP

The INTO recommends that:

- 0 The defined roles and work areas of the teacher and the speech and language therapist should be clarified at an early stage, on the establishment of the class or a change over of personnel. Prior consultation with all parties involved is recommended. A mutual appreciation of the professional responsibilities and parameters of the respective roles should be encouraged, and
- 0 Regular meetings should be arranged involving teacher, speech and language therapist, principal teacher and principal speech and language therapist to discuss issues that affect the smooth operation of the language class. The principal teacher and the principal speech and language therapist should foster good relations and use their influence to resolve difficulties. Guidelines for collaborative interaction from the DES would be helpful.

POSITION OF THE SPEECH AND LANGUAGE THERAPIST IN THE SCHOOL .

The INTO recommends that:

- 0 The DES examine the feasibility, of employing speech and language therapists directly to work in school settings.

FUNDING AND RESOURCES

The INTO recommends that:

- 0 There is an urgent need for an improvement in funding. The current capitation grant needs to be increased significantly;
- 0 An establishment grant should be made available to new language classes and the class teacher should be given an annual grant for on-going expenditure. An additional allowance is also required to cover the cost of photocopying materials for the speech and language therapist and phone costs;
- 0 Suitable ICT hardware and software should be made available to the language classes;
- 0 Substitute cover should be provided when speech and language therapists are on holidays etc;
- 0 Special needs assistants should be appointed to the language class as required;
- 0 Speech and language therapists should be available in the language class for the full day.

INTEGRATION

The INTO recommends that:

- 0 Members of staff should be encouraged to facilitate the integration of pupils attending the language class. Children enrolled in the class should have an opportunity to work in a larger group setting in subject areas such as physical education, art, religion and music etc. on an ongoing basis. This will enable them to adapt more readily to mainstream education when they return to their local school.

- 0 Schools should develop their own policy, as part of School Planning, for integrating children from the language class. The school principal should try to ensure that integration is facilitated.

PROFESSIONAL DEVELOPMENT NEEDS OF TEACHERS , PRINCIPALS AND SPEECH AND LANGUAGE THERAPISTS

The INTO recommends:

- 0 The provision of a Special Education Diploma Course with a generic module in the first term followed by a specialist module relevant to the work of the language class teacher. Such a course would have to be devised in collaboration with various bodies such as the Colleges of Education, School of Clinical Speech and Language Studies, INTO, ISALT, Special Education Section of DES.
- 0 Courses should be accessible to all the teachers involved, regardless of the geographic location of the language class. The mode of delivery of such a course needs to reflect accessibility. The provision of a part-time, regionally-based distance education course should be considered. Such a course could be modular in nature with a recognised award on completion of all modules.
- 0 Appropriate professional development for teachers and speech and language therapists should be provided which facilitates the development of collaborative work.
- 0 An annual seminar for teachers and speech and language therapists and other professionals involved in the language classes should be facilitated by the DES.
- 0 Induction for all teachers and speech and language therapists should be provided as part of the process of

establishing a language class.

- 0 School principals should meet with other principals in the Health Board region as required, and inservice specific to school principals should be organised as a module of the overall programme for teachers.
- 0 Formal recognition should be given and provision made for adequate time for the teacher and the speech and language therapist to plan, evaluate, and work in a collaborative manner.

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