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Citation: Pring, T., Flood, E., Dodd, B. & Joffe, V. (2012). The working practices and clinical experiences of paediatric speech and language therapists: a national UK survey. *International Journal of Language & Communication Disorders*, 47(6), pp. 696-708. doi: 10.1111/j.1460-6984.2012.00177.x

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Permanent repository link: <https://city-ref-test.eprints-hosting.org/id/eprint/3338/>

Link to published version: <https://doi.org/10.1111/j.1460-6984.2012.00177.x>

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The working practices and clinical experiences of paediatric speech and language
therapists: A national UK survey

Tim Pring, Emma Flood, Barbara Dodd and Victoria Joffe
(Department of Language and Communication Science,
City University, Northampton Square, London EC1V 0HB)

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Abstract

Background: The majority of speech and language therapists (SLTs) work with children who have speech, language and communication needs. We have limited information about their working practices and clinical experience and their views of how changes to health care may impact upon their practice.

Aims: To investigate the working practices and professional experiences of paediatric SLT's working in the UK through an online survey.

Methods & Procedures: The survey was conducted on line using Survey Monkey. Therapists were alerted to the survey through the Bulletin of the Royal College of Speech and Language Therapists and by emails to national special interest groups.

Outcomes & Results: Five hundred and sixteen clinicians completed the survey. A large majority worked in the National Health Service. A varied pattern of working was revealed. Most worked in several settings and saw a range of clients.

A typical clinician spends less than a quarter of their time giving direct therapy and more than a quarter training parents and other professionals. Nearly a half of respondents felt that their time could be better used. Too little time for direct therapy and the time required for administration emerged as their principal concerns.

Most clinicians have specialist knowledge of particular client groups and spend more

time with them than do non-specialists. Nevertheless, clients are more likely to be treated by a therapist who does not claim to have specialist knowledge of their condition than by one who does. The only clients for whom this is not the case are those with dysphagia.

Eighty per cent of respondents felt that proposed changes to the NHS would not benefit the children they treat and there was widespread concern about cuts and the effects of GP commissioning. Despite this a large majority expected to remain speech and language therapists five years from now.

Key words: survey, clinical practice, speech and language therapist, clinical experience, paediatric speech, language and communication needs

What we (don't) know

What is the working life of a paediatric therapist like? How do they divide their time and do they think this makes best use of their skills? Where do they work and which clients do they see? How many clinicians consider themselves specialists and how do they see the service changing in the future?

What this paper adds

Responses to a questionnaire by 516 paediatric therapists give information on their work, the types of clients they see, their specialist knowledge and how this affects the service they offer clients and their views on how changes in the National Health Service may affect these services.

Introduction

Most speech and language therapists (SLTs) work with children and young people with speech, language and communication needs (SLCN). Gascoigne (2006) found that 70% of the 10,000 SLTs working in the UK are paediatric therapists. They work with a wide range of clients including those with language, speech, voice, hearing, fluency and social communication problems and across a wide age range (0-19 years; but to be extended to 25 following recommendations of the green paper on Special Education Needs, Department for Education 2011). In a survey exploring the recruitment and retention of SLTs, Rossiter (2008) found 'a considerable widening of the SLT role' (p. 14) to include, for example, dysphagia, mental health, autism and acute paediatrics.

A wide range of problems and disabilities may affect children's communication with the result that SLTs have varied and challenging caseloads. They also work in a range of settings including hospitals, nursery, primary and secondary schools, community clinics, children's centres and clients' homes. As a result they work with a variety of other professionals and with the family members of the children they treat and play many different roles - therapist, counsellor, teacher, clinical tutor and clinical supervisor. The models of service delivery they follow and types of interventions they use also vary. Lindsay et al. (2010) in a survey of interventions undertaken by paediatric SLTs identified 158 different types.

How much do we know about the complex and varied working lives and professional practices of paediatric speech and language therapists? Much of the information we have comes from anecdotal sources and may be unrepresentative. Commonly heard complaints may be those of a vocal minority. These may dwell on the

exceptional and, perhaps, negative aspects of the work rather than everyday good practice. Clinicians often complain that they spend too much time on administrative tasks and too little seeing children who need their services and that they are training others to work with children at the expense of giving therapy themselves. We know too little about the methods they use to assess children and the treatments they offer; nor do we know whether there is agreement on which assessments and treatments are best or whether treatments are theoretically well founded or based on clinical intuitions and passed on experience. At a time of health service reform it is also important to know clinicians views on the changes and challenges to their current practices.

Some information is available on these issues. The Bercow review (DCSF, 2008) observed that therapists are increasingly being asked to train and delegate their work to others. In response, a Royal College of Speech and Language Therapists' (RCSLT) policy statement (RCSLT, 2010a) clarified therapists' clinical responsibility regarding delegation and provision of training. These guidelines see delegation as an essential part of the service to which newly qualified therapist should contribute. The review noted other findings consistent with common complaints. These include gaps in the service, a 'postcode lottery' for accessing therapy services and lengthy waiting times for identification and intervention (DCSF, 2008).

The economic climate and financial cuts including changes to the commissioning of speech and language therapy services will make it difficult for managers and the profession to maintain high quality services. A survey by the RCSLT found that SLT services are facing mergers with other departments, budget cuts and staff reductions (RCSLT, 2010b). The Chief Executive of the RCSLT, has highlighted the potential harm that financial cuts to public services will have for people with SLCN and the

danger that SLT services will be seen as a 'soft target' (Gadhok, 2010a, p.8) and has identified the need for up-to-date information on what is happening in clinical practice (Gadhok, 2010b). In response to these threats RCSLT is stressing the need to commission SLT services and that meeting the needs of individuals with SLCN is consistent with government policy, such as the health inequalities agenda (Gadhok, 2010a). In a period of change, it is important to understand more of the current structure and functioning of the profession and its attitude to reform.

A number of surveys of SLTs views have been conducted. Several have asked about specific and relatively circumscribed topics. For instance, Vallino-Napoli and Reilly (2004) found that Australian therapists valued research and that most were aware of evidence based practice but that lack of time prevented them from using evidence or contributing to research. Others have looked at the recruitment and retention of SLTs' and their job satisfaction and career progression (ASHA, 2008; Loan-Clarke et al, 2009; Rossiter, 2008). Findings are of a high level of retention encouraged by the positive nature of the work, job and pension security and the opportunities for training and career progression. Those leaving mentioned the high work load, stress and poor pay. Watts Pappas et al. (2008), again surveying Australian therapists, found that the service for children with speech disorders often involved parents in the delivery of therapy but rarely in planning treatment and that a minority had significant reservations about the role of parents. Dockrell et al (2006) asked SLT managers about service delivery and educational provision for children with language disorders. Prominent themes within their findings are the lack of a common terminology to guide decision making and the increasing trend towards indirect therapy by teaching assistants and other professionals. Clinicians are unlikely to be surprised by these findings which, to an extent, show that the concerns

that they have are not limited to the service in the UK.

Fewer surveys have looked at the therapies and assessments that clinicians use. This may reflect the lack of widely acknowledged therapies and of a common terminology for their description. This problem is seen in large number of responses to the survey by Lindsey et al (2010) of the interventions used with children with SLCN. Two surveys have looked at the assessments used by therapists treating children with speech disorders in the US and in the UK (Skahan et al, 2007; Joffe and Pring, 2008). A similar profile was found in each with a strong favourite emerging from a large number of assessments. However, the favourites differed and there was almost no overlap in assessments used in the two countries. Joffe and Pring (2008) also offered respondents 13 therapies from which to indicate their preferred approach. Clinicians used an eclectic approach combining different therapies with auditory discrimination, minimal contrast therapy and phonological awareness frequently used in combination.

We conducted an on-line survey of paediatric speech and language therapists working with children and young people with SLCN. The present paper reports data about how their work is structured. In a companion paper, we look at their clinical methods – what assessments and therapies they use with different client groups, how long clients must wait for therapy, how much therapy they receive and how it is administered (Joffe et al., in preparation).

The issues examined in this paper concern (1) how SLTs divide their time between different aspects of their work, (2) whether they feel that this division makes the best use of their time, (3) where and with which client groups they work, (4) whether they

have developed specialist skills with particular client groups and to what extent this affects the service that is offered, (5) how they view their future career and (6) how they feel the speech and language therapy service will be affected by reforms to the NHS.

Method

Procedure

The questionnaire was made available through Survey Monkey, an online survey software and questionnaire tool. An invitation to paediatric speech and language therapists working in the UK to access and complete the questionnaire was published in the RCSLT Bulletin on two occasions. The on line survey remained accessible for a six month period (July-December 2010). Notice of the survey was also emailed to clinicians via national special interest groups.

Questionnaire

The questionnaire (see appendix) was designed to obtain information about the respondents' clinical experiences and practices. It consisted of three sections:

Section A had 17 questions focusing on the respondents' level and type of clinical experience, their areas of specialism, working practices, work settings and the use of their time.

Section B asked for detailed information about the assessment, treatment and management of specific diagnostic groups. Information from this section is not reported in this paper and it is omitted from the appendix.

Section C: consisted of 2 questions asking whether proposed changes in healthcare would benefit children with SLCN and whether they would continue working as SLT's in the future.

Development of the questionnaire

A questionnaire was developed to cover areas of interest after consultation with other SLTs and with SLT managers. We consulted Communicating Quality (2006) to determine the types of clients that paediatric therapists treat. The draft questionnaire was piloted by volunteers. Changes in wording were introduced where confusions arose.

Two major changes were made. We wanted information on whether therapists were able to develop specialised skills with particular clients and the extent to which they could use these skills. The job titles 'specialist' and 'highly specialist' are used and we asked respondents to give us their job title in the questionnaire. However, the title alone does not indicate which types of client a therapist specialised with.

Discussions with managers revealed that these titles are used inconsistently and not at all in some services (subsequently confirmed by the varied titles given by respondents). We therefore asked respondents to 'indicate the areas in which you consider yourself to be a specialist'.

Several questions asked respondents to indicate the time they spent on different activities or the time they spent with different types of clients by giving percentages. It became apparent that respondents found it difficult to give exact figures. Some complained of the difficulty getting their figures to add to 100%; others gave in figures which did not do so. To simplify responding we asked respondents to indicate the time spent in 5 broad categories (none, 1-25%, 26-50%, 51-75% and 76-

100%). This clearly sacrificed accuracy but made responding easier and avoided possible failures to answer these questions.

Data analysis

Both quantitative and qualitative data was available. Questionnaire responses were downloaded from Survey Monkey and placed on SPSS data files (SPSS v17, 2008). Much of the quantitative data were in the form of categorical responses and chi square tests were used to compare different categories. We calculated summary statistics from the categorical responses to give a clearer picture of clinicians' workload. These estimates are presented as descriptive statistics and are not subject to further statistical analysis. Qualitative responses were examined for recurring themes and opinions.

Results.

Who responded and are they representative?

Five hundred and sixteen clinicians responded to the questionnaire before the cut-off date (about 7.5% of paediatric therapists). The respondents appeared to be broadly representative of paediatric therapists. Their places of work covered all areas of the UK and appeared to reflect the distribution of the population. As the data below shows they worked with all the client groups specified in the questionnaire and in a variety of settings. They had a range of experience (0-2 years 17.3%, 3-5 years 20.3%, 6-10 years 19.9%, over 10 years; 42.5%). Respondents overwhelmingly worked in the National Health Service (NHS) (87.6%) with 7.1% in private practice. Sixty five per cent (65.4%) worked full time and there was a strong relationship between experience and full time work (chi square (d.f. = 3; n = 507) = 109.9, $p <$

.001). Part time working increased with years of experience and 59% of clinicians with more than 10 years' experience worked part time with the majority (74%) working 3 or 4 days a week. There is a relationship between the respondents' salary band and whether they work full or part time (chi square (4, 472) = 38.34, $p < .001$). This is primarily due to recently qualified therapists who are overwhelmingly full time and are band 5. However, a significant association remains when the data from band 5 respondents and for the sole respondent on band 9 are removed (chi square (2, 386) = 14.55, $p < .01$). Part time therapists are overrepresented in the higher bands though whether promotion or part time working came first is unclear.

We were interested in respondents' job titles and the extent to which this indicated experience in the profession or specialist responsibility. A bewildering array of titles indicating degrees of seniority were offered. Twenty six described themselves as head of service/service manager/team leader, 27 as coordinator or clinical lead, 20 as principal and 10 as senior speech and language therapist. Titles indicating specialist roles were more straightforward. Four were consultants, 79 were highly specialist, 112 specialist and 4 developing specialist (thus only 38.6% of respondents had job titles indicating specialisation, confirming the advice given by managers that job titles would not adequately identify specialist interests).

How do clinicians spend their time?

Respondents were asked how they divide their time between different aspects of their work. They were asked how much is spent treating clients directly and how much time is given to training other professionals or parents to work with them (indirect therapy), how much time they spent assessing clients, writing reports and referral letters, attending meetings and in other administrative tasks. The number of

responses in each quartile is given in Table 1 (no respondents gave 'none' as an answer). The final column gives an estimate of the mean percentage time spent on each activity (see note 1 for an explanation of these estimates). The time spent in direct intervention is less than a quarter of working time (but this is the most varied activity with 119 clinicians spending more than half their time) and the remainder is evenly divided between the other six areas. The amount given to direct therapy is quite small, however direct and indirect therapy together add to half of total time.

Insert Table 1 about here

We examined whether the distribution of working time changed with experience. No differences were found in therapy time, either direct or indirect. More experienced therapists spent significantly less time writing reports (Chi Square (9, 495) = 44.41, $p < .001$) and significantly more time in meetings (Chi Square (9, 487) = 18.35, $p < .05$). Too much should not be read into these results, however. The result for time spent in meetings is largely due to a few therapists spending a lot of time in them while others managed to avoid them. Equally, it is unclear whether they actually write fewer reports or whether their experience has made them more proficient at doing them.

We also asked respondents to say if the distribution of their work made the best use of their time. A narrow majority said yes; however 44.7% thought it did not. This is a matter of concern and we examine it in two ways. We compared the work patterns of those who answered yes and no to the question. We also asked respondents who answered no to give us their ideal patterns of work, i.e. ones that would make better use of their time, and compared these with their actual use of time.

Insert Table 2 about here.

Table 2 gives the responses of clinicians who did and did not say their work made the best use of their time. The groups were compared and significant differences found for direct therapy (chi square (3, 491) = 17.94, $p < .001$), report and referral letter writing (chi square (3, 491) = 41.93, $p < .001$) and other administration (chi square (3, 480) = 26.65, $p < .001$). The final column gives the amount of time spent on each activity by each group calculated as previously and confirms that those who feel their time is not best used do less direct therapy and more report and letter writing and other administration than those who believe their time is well spent.

Insert Table 3 about here.

Table 3 compares the actual working time of those who felt their time was not well spent with their 'ideal' distribution which would make better use of their time. This confirms the pattern seen above and strikingly demonstrates their concerns. They currently spend 45.8% of their time doing direct and indirect therapy (not far behind the overall average of 50%) but would like to see this increased to 64.5% with a corresponding drop in administrative tasks.

Respondents were asked what percentage of children in their caseloads had English as an Additional Language (EAL). This revealed wide variation. Fifty seven (11 %) said that they had none. The distribution was strongly positively skewed reflecting the minority of clinicians who work in areas with a high level of EAL families. Twelve per cent said they had 70% of children with EAL or above. The median value is 12%; the mean is 27.6% (s.d. = 28.98).

Who do paediatric therapists treat?

Respondents were asked to say what ages of children they treated classified by 5 levels (infants, pre-school, junior primary, senior primary and secondary). Most

worked with a range of ages; 110 (21.7%) worked in all five and only 35 (6.9%) worked in only one (14 in secondary schools and 10 with preschool children). The mean number of age groups across clinicians was 3.33. This appeared to change little with experience. Those who had worked for over 10 years and were often part time were slightly more likely to work with several age groups.

Respondents were asked to indicate the places in which they worked. Mainstream schools (67.4%) were the main setting. Many also worked in clinics (52.3%), special schools (25.4%) and language units (23.5%). The mean number of settings per clinician was 2.34 with some in 5 or 6 different locations. Moreover, these figures underestimate the nomadic life of the SLT since many may go into several schools or clinics.

Insert Table 4 about here.

Respondents were asked to indicate the types of clients that they work with, the amount of time they work with them and whether they considered themselves to be specialists with these clients. Just as clinicians work with different age groups and in several settings, so they work with a wide variety of clients. Table 4 shows the numbers of therapists working with each type of client the amounts of time spent with them and whether the respondents consider themselves to be specialists in that area. Speech, language, autism and learning difficulties are the main areas of work reflecting the large numbers of clients in these groups. Chi square tests comparing the distributions of time for specialists and non specialists in these areas were significant ($p < .001$). Numbers in the other client groups were too small to be reliably analysed but, with the exception of voice where there are too few clients to occupy either specialist or non specialists, a similar pattern is seen. With one

exception specialists are a minority but are likely to spend more of their time with their favoured clients. Dysphagia is the exception. Few therapists work in the area (79.6% of clinicians do not see clients with swallowing difficulties) but a higher percentage say they are specialists than in any other area reflecting the view that extra training and/or experience is required.

These findings may not seem surprising. Clinicians develop specialised interests in the client groups they work with; alternatively they may seek to work with clients they are most interested in (a few respondents said they had specialised interests in client groups they were not working with). The converse of this is that many clinicians work with a variety of clients and fail (or do not have the opportunity) to develop a specialised interest. Table 5 examines this from the perspective of the clients. The first two columns estimate (as previously) the amount of time given to the different clients by non-specialists and specialists. By multiplying each by the number of clinicians involved we obtained a measure of the total amount of time given by our respondents. This allowed us to get the percentage of the total time that was offered by clinicians who considered themselves specialists in the area (final column).

Insert Table 5 about here.

These figures are estimates and should be treated with caution. Moreover, the greater percentage of time given by specialists may be an overestimate since experienced therapists who are more likely to specialise are also more likely to work part time. However, the figures give a general indication of a client's likelihood of being treated by a clinician who thinks of herself as a specialist in an area. An indication of their general accuracy is that dysphagia, widely considered to require experience and/or further training is the area in which clients are most likely to be

treated by specialist clinicians.

These figures give a confusing message as to the degree of specialisation within the profession. Specialists spend more of their time with the client groups with which they specialise than do non-specialists but the amount of time is surprisingly small with only clinicians working with clients with hearing impairment and with cleft palate spending more than half their time with their chosen client group. Consider this from the client's perspective. Those with a speech or language disorder, the two largest groups, have a 37 and 46% chance of being seen by a therapist who considers herself a specialist in the area. Less common client groups whose needs are more easily recognised and more specific (e.g. cleft, hearing impairment, cerebral palsy) have only a 2 or 3 in ten chance being treated by a therapist who specialises in the area.

Over a third of respondents (36.42%) did not consider themselves to be a specialist in any area. Unsurprisingly there was a strong relationship between experience and specialism ($\chi^2(12, 508) = 137.40, P < .001$) with those least experienced being unlikely to consider themselves specialists. However, even among the most experienced (more than 10 years), 45 clinicians (20.8%) did not consider themselves to be a specialist in any area.

Respondents were asked if their caseload allowed them to make full use of their specialist skills; one fifth (20.5%) replied no. Their comments revealed frustration at their inability to use or to develop their specialist knowledge. Many were required to be generic therapists because of the structure of their service (particular so in rural areas). Specialists in areas with few clients found it difficult to maintain their expertise. Heavy caseloads were blamed for lack of time to improve expertise

through reading and training and for the inability to pass on specialist skills to less experienced clinicians. Paradoxically a few said that their caseload was too small. These were therapists with management roles and limited clinical time. An additional concern was the difficulty of maintaining or developing specialist interests where there was limited face to face contact with clients or where blocks of therapy were no longer offered. In contrast, some respondents said that they preferred the variety offered by being a generic therapist and had not sought to develop a specialist interest.

Changes in the NHS and the future of SLT

Respondents were asked whether they were likely to be working as a speech and language therapist in five years' time and whether they felt that changes in the health service would benefit the SLT service for children or not. These questions produced large and, in some ways, contradictory majorities. Eighty seven per cent expected to remain as speech and language therapists despite 80.7% feeling that the changes would not benefit children.

Those who thought they would not be a therapist in 5 years' time were asked why. A few who said they would remain a therapist decided to contribute here perhaps seeing an opportunity to voice complaints. As a result these comments were largely negative and may not reflect the views of the silent majority. They are largely consistent with the findings above, however. Frustration with working practices in the NHS were a primary cause of complaint particularly the lack of time for direct therapy and the scale of administration – 'I feel like I sit behind a computer for most of the day'. Some said that their job felt insecure and a few said that their job was to be cut. Natural wastage played some part – 14 were due to retire within 5 years.

Comments from the majority who felt that current changes would not benefit children repeatedly voiced the same concerns -- that services were being cut, jobs frozen and that waiting lists were lengthening and that there was worse to come (responses dated from the second half of 2010). Several asked how 'efficiency savings' could improve the service when they reduced the number of front line staff and others said that the situation was creating insecurity about jobs and career prospects. Cuts to children's centres and the lack of understanding of the need for early intervention were often mentioned. Some commented that the re-grading of experienced staff and the pressure they were under had made them unable to help those new to the profession. One therapist with 35 years of experience commented that 'the last lot of reforms pulled our team apart and we lost all the good work I had fought so hard to achieve'.

Respondents were alarmed at how commissioning by general practitioners (GPs) would affect services. One remarked that SLT was 'a soft target so at risk of cuts' and that 'it is about quality of life not saving lives'. Commissioning was expected to 'follow the medical model'. Respondents were also sceptical about whether GPs had sufficient awareness of the services offered by speech and language therapists. In support several commented on the few referrals currently made by GPs and on the nature of those that did occur. One commented 'on the rare occasions I have received referrals from GPs they have always been for "speech difficulties"' and another that she 'had never received a GP referral for a language difficulty' and that 'although I copy all my reports to GPs no GP has ever contacted me'. A number of respondents felt that the proposed new methods of commissioning services would limit their clinical autonomy presumably suggesting that they will lose their role in prioritising those children who are in most need and will fail to have referred others

who need help.

A further concern already evident from the data above was that cuts made it more difficult to work directly with children and added to a trend in which therapists' role is to train others (particularly SLT assistants and teaching assistants) to carry out their work. Some stated bluntly that they thought indirect therapy did not work; others while agreeing that support from a child's significant others was important felt that it 'is not a substitute for face to face therapy and should be used alongside it' and that there would always be some children who require 'intensive specialist intervention which cannot be provided by a teaching assistant'. A related concern was that therapists themselves would become 'deskilled' in their primary role or that new entrants to the profession would never gain these skills. One new entrant complained that she was "asked to train others to conduct therapy despite having had almost no opportunity to practice it herself". Another said that "we didn't train for 3 or 4 years just to pass on our skills to untrained staff".

The minority who said that changes might be beneficial seemed to be taking a stoic approach to the issue. They appeared as dismayed by cuts as the others but thought that these might force a reappraisal of the services offered. Some felt that this might improve efficiency by concentrating services more selectively on those children who most needed help.

Discussion.

Many of these findings reflect and to an extent confirm the anecdotal evidence that we were disinclined to trust prior to the survey. There is discontent with the lack of time for therapy and for direct therapy in particular and for the amount of time spent on administrative tasks. A substantial minority felt that their time was not well used.

Most therapists see a wide range of clients and have little chance to develop a more specialised knowledge of particular clients. A large majority are concerned about the future of the service as cuts and changes in the NHS impact upon it, concerns also expressed by RCSLT (Gadhok, 2010a; 2010b; RCSLT 2010b).

Despite these complaints, very few (13%) said that they would not be a speech and language therapist in 5 years' time. Rossiter (2008) also found a high level of retention and Loan-Clarke et al (2009) found that the profession offers job security, pension and opportunities for professional development which add to the rewards of the work. A further factor may be that the profession is flexible. Just over a third of our respondents worked part time and a majority of those who had worked for over 10 years did so. We assume, though we did not ask, that a majority were female for whom part time work may be more appealing. Moreover, part time working appears not to impede advancement. Part timers were more likely to be on higher salary bands.

As expected, the working life of our respondents was nothing if not varied. They worked with children of different ages and in a variety of settings. Many saw most if not all the diagnostic groups. This pattern is so common that we must assume there are benefits of working in this way or that circumstances require it. It may be a necessity in small towns and rural areas. However, it is common throughout the profession and few respondents worked with a restricted range of clients. This pattern obliges most therapists to be generalists, competent in catering for clients with different problems and ages but less able to develop specialist skills. Why this system persists in areas with larger client populations is unclear. A more specialised service would surely be both more efficient and foster greater expertise.

A striking aspect of the data to those unfamiliar with the profession is that the average therapist spends less than a quarter of their time working directly with clients. A further 13 per cent of time is spent giving and analysing assessments. Given the time devoted to this it is understandable that therapists are frustrated at the lack of time for face to face therapy. Instead they spend more time training other professionals and parents. Training of others is a growing trend within the profession and is the subject of a recent policy statement by the RCSLT (2010a). Dockrell et al (2006) reported that indirect therapy is the predominant form in mainstream schools. The managers they surveyed favoured this as a means of increasing provision but parents favoured one to one provision.

Nearly half our respondents felt their time could be more effectively used by giving more time to direct therapy and spending less time on administration. They did not want a reduction in indirect therapy, however. There is evidence in the literature of the value of training others (Allen and Marshall, 2011; Bowen and Cupples, 2006; Boyle et al, 2009; Fey et al, 1993; Wilson et al 2010). Our respondents agree but believe that this should be in addition to, rather than replacing their own services.

As expected children with speech and/or language disorders were the largest client groups in our survey and attract the greatest numbers of specialist therapists. A surprisingly high number specialise in treating children with autism. Shriberg and Kwiatkowski (1994) estimated that 7.5% of children have speech difficulties and Tomblin et al (1997) found that 7% of children have specific language impairment. These figures contrast with an estimate (Baron-Cohen et al., 2009) that only 1.57% of children have autism and suggest that a disproportionate number of clinicians specialise in the area. The number may reflect the intense publicity and media

interest that has surrounded autism.

Our data suggests that conflicting trends exist within the profession. Most therapists work with and must be confident treating different types of clients. Yet they are often referred to as specialist, highly specialist and consultant therapists. The last, a recent development, are expected to play an advisory role, be involved in research and to have contacts with academic SLT departments (RCSLT, 2010a). The contrast here is between 'therapy' as a general set of skills that can be used with many clients and specialist knowledge of particular diagnostic groups. Ideally clinicians should have both but with a variety of clients to treat it may be difficult to acquire the latter for all the clients they see. As the evidence base for different treatments improves this conflict may increase. Most of our respondents had specialist knowledge in at least one area. However, with one exception – dysphagia – non-specialists treating each diagnostic group outnumbered specialists with the result that more than half of all treatment was given by non-specialists (again with the exception of dysphagia). This is not a criticism of the current system - the standards of proficiency for SLTs stipulate that all graduates show competence in working with all client groups (Health Professions Council, 2007). However, it suggests that the current service does not encourage greater specialisation or allow therapists to spend more time with the clients they are most able to treat. This suggests there may be a limit to career progression for SLTs. Rossiter (2008) who surveyed the availability of SLT posts over a 10-year period reported a decline in specialist posts and urged the profession to 'defend specialist skills and experience' (p. 15). The exception of dysphagia suggests that where an overriding clinical need exists, greater specialisation is achieved. Will this remain an exception or become the model for other diagnostic groups as the evidence base for their treatment

increases?

Eighty per cent of respondents felt that proposed changes to the NHS would not benefit children with SLCN. This figure is comparable with those found for other health care workers (less than 1 in 4 doctors believe the reforms will improve patient care (Nowotny, 2010)). These figures prompted one critical source to say that “It would be hard to find a modern precedent for a major piece of legislation (the Health and Social Care Bill) which was so universally condemned by everyone best qualified to understand it” (Leys and Player, 2011 p 144-145). SLTs no doubt share many of the reservations of other health professionals, but have additional concerns of their own. Particular concerns are GP commissioning and the survival of a SLT service in a market for health care funding. Many felt GPs did not understand the role of SLT and would not prioritise the service. The reality may be worse. Leys and Player (2011) give examples of private health care companies, many from the United States, taking over commissioning budgets from which they plan to deduct their profits and make payments to the GPs involved.

Is speech and language therapy a profession in crisis? Many of our respondents complained of bureaucracy in the NHS and of the lack of time for therapy. Some were tempted to become private therapists, a trend that may be hastened by other moves to privatise healthcare. The prospect of a two tier service with the public sector under-funded and SLT services to many children with SLCN limited and inaccessible is uninviting. However, our survey also suggests that our respondents’ concerns are balanced by a continuing loyalty to the profession and a commitment to the ideals that brought them into it.

Note 1. In these and subsequent calculations we used the following approach. The mean of grouped data may be obtained by multiplying the number of participants in each group by its midpoint. Adding these figures and dividing by the total number of participants will give the mean. This procedure was followed but the means obtained are clearly overestimates. This is because the distributions are positively skewed and respondents at the upper end of the distribution are more likely to be below than above the midpoint. This was confirmed by the figures obtained which add to more than 100%. To correct this overestimate we reduced the figures proportionately so as to total 100%. We regard these figures as estimates (in the general rather than the statistical sense of the word) and they should be treated cautiously. They are presented as descriptive statistics and no further calculations were based on them. Nevertheless they give us an indication of the relative times given to different activities and, given the difficulty that respondents in the pilot testing had in giving more precise figures are likely to be as good an indication as we are able to obtain.

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Table 1. Distribution of time given to different activities.

	1-25%	26-50%	51-75%	76-100%	total	Estimated % of time
direct intervention	185	194	103	16	498	22.46
indirect intervention other professionals	323	143	20	9	495	14.83
indirect intervention parents	372	96	11	8	487	12.70
Carrying out and analysing assessments	360	107	23	2	492	13.21
reports and referral letters	342	133	19	3	497	13.83
meetings	421	46	16	5	488	11.09
other administration	388	80	17	1	486	11.88

Table 2. Distribution of time for different activities for clinicians who said their time was well spent (yes) and those that did not (no).

	Time well spent	1-25%	26-50%	51-75%	76-100%	n	Estimated % of time
direct intervention***	yes	92	96	68	14	270	25.00
	no	89	97	34	1	221	19.38
indirect therapy with professionals	yes	180	73	11	4	268	14.84
	no	139	68	9	5	221	14.72
Indirect therapy with parents	yes	201	51	8	4	264	13.19
	no	165	45	3	4	217	12.16
Doing assessments	yes	206	50	11	1	268	12.87
	no	149	56	12	1	218	13.55
Reports/referral letters***	yes	217	50	2	2	271	11.91
	no	121	81	17	1	220	15.94
meetings	yes	230	22	10	4	266	11.61
	no	187	24	5	4	220	10.92
other admin***	yes	231	25	6	0	262	10.58
	no	151	55	11	1	218	13.33

Note: The final columns give the numbers of respondents and the % time spent on each activity by those who feel their time is and is not well spent. ***indicates results significant at $p < .001$.

Table 3. Comparison of real and ideal distributions of working time for those respondents who felt the best use was not made of their time.

		1-25	26-50	51-75	76-100	n	Estimated % of time
Direct intervention.	real	82	89	31	0	202	18.81
	ideal	15	79	93	15	202	28.32
Indirect therapy with other professionals.	real	116	64	9	4	193	14.89
	ideal	61	103	26	3	193	18.77
Indirect therapy with parents.	real	142	43	3	3	191	12.12
	ideal	72	99	15	5	191	17.44
Carrying out and analysing assessments	real	122	52	12	0	184	13.85
	ideal	133	47	5	1	184	11.57
Reports and referral letters	real	98	75	15	1	189	16.16
	ideal	166	21	2	0	189	8.79
meetings	real	157	20	5	3	185	10.72
	ideal	178	4	1	2	185	7.86
other admin	real	127	51	10	1	189	13.45
	ideal	186	2	1	0	189	7.25

Table 4. The distribution of time spent working with different types of client by clinicians who consider themselves specialists or not specialists with those clients.

	Specialist Yes/no	Number and % of specialists and non- specialists.	1-25%.	26-50%	51-75%.	76-100%
Speech***	yes	132 (30.8)	65	45	20	3
	no	296 (69.2)	203	68	19	6
Language***	yes	175 (39.7)	32	89	35	19
	no	266 (60.3)	108	102	44	12
Autism***	yes	100 (24.2)	35	25	30	10
	no	313 (75.8)	222	71	16	4
Learning Difficulties***	yes	89 (24.5)	22	26	19	22
	no	274 (75.5)	204	51	12	7
Dysfluency	yes	44 (17.6)	31	7	3	2
	no	206 (82.4)	197	9	0	0
Voice	yes	6 (6.1)	6	0	0	0
	no	92 (93.9)	91	0	1	0
Cleft Palate	yes	9 (3.0)	3	2	0	4
	no	128 (97.0)	126	1	0	1
Cerebral Palsy	yes	35 (19.9)	17	11	5	2
	no	141 (80.1)	125	12	4	0
Hearing Impairment	yes	19 (10.1)	4	5	2	8
	no	169 (89.9)	157	9	1	2
Dysphagia	yes	48 (50.5)	17	14	10	7
	no	47 (49.5)	44	3	0	0
Literacy	yes	21 (14.4)	8	8	3	2
	no	125 (85.6)	108	9	6	2

*** p < .001

Table 5. The percentage of time spent working with different types of clients by non-specialists and specialists and the percentage of time that clients are seen by specialists.

	Estimated % of time spent with clients by non-specialists.	Estimated % of time spent with clients by specialists.	% of total time given by specialists
Speech	22.97	30.39	37.11
Language	33.74	43.35	45.81
Autism	21.68	41.25	37.80
Learning Difficulties	21.26	49.01	42.81
Dysfluency	13.59	23.01	26.55
Voice	12.37	12.50	5.88
Cleft	13.49	51.38	21.38
CP	16.04	31.78	32.96
Hearing Impairment	15.01	55.92	29.51
Dysphagia	14.09	41.14	74.88
Literacy	17.90	36.30	25.42

Appendix

A Survey of Paediatric Speech-Language Therapy Services in the UK

Section A

1. How many years of clinical experience do you have (tick the box):

0-2 ☐

3-5 ☐

6-10 ☐

>10 ☐

2. Do you work full or part time? Full time ☐ Part time: ☐

3. If part time, how many days do you work as a clinician?

4. What band are you?

5. What is your job title?

6. What geographical area do you work in?

7. Which of the following children do you work with? (you may tick more than one)

Age range: Infants (<2 years) ☐

Preschool (2-4.6) ☐

Junior primary school (4.7-7) ☐

Senior primary school (8-11) ☐

Secondary school (11-18) ☐

8. Who employs you?

NHS ☐

Local Authority ☐

State or Private School ☐

Private practice ☐

University ☐

Other ☐

If other, please specify.....

9. Places of work:

- Clinic ☐
- Mainstream School ☐
- Special School ☐
- Language Unit/Resource Base ☐
- Hospital ☐
- University ☐
- Home ☐
- Other ☐

If other, please specify.....

10. Please indicate in the table below what % of your time is spent with each client group with whom you work?

11. And indicate the areas in which you consider yourself to be a specialist?

Area	none	1-25%	26-50%	51-75%	76-100%	Specialist? (tick)
speech						
language/SLI						
autism						
learning difficulties (general)						
Stuttering(dysfluency)						
voice						
Cleft palate						
cerebral palsy						
hearing impairment						
dysphagia						
Literacy/dyslexia						

other (specify)						
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12. Does your current caseload allow you to make full use of your specialist skills?

Yes ☐ No ☐

13. If you answered no to question 12, what prevents you from doing so?

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.....

.....

14. What percentage of your caseload is made up of children who speak English as an additional language?

15. What percentage of your work time is spent on?

	none	1-25%	26-50%	51-75%	76-100%
Direct Intervention					
Indirect Intervention – consultation with other professionals, for example, teaching staff					
Indirect Intervention – consultation with parents and family					
Assessment and analysis of assessments					
Writing reports and referral letters					
Other administration duties					
Meetings					
Other activities (specify)					

16. Do you feel that your workload and activities (as reflected in the table above in question 15) makes the best use of your time and skills?

Yes ☐

No ☐

17. If you said No to question 16, indicate ideally how you think your time would be better used.

	none	1-25%	26-50%	51-75%	76-100%
Direct Intervention					
Indirect Intervention – consultation with other professionals, for example, teaching staff					
Indirect Intervention – consultation with parents and family					
Assessment and analysis of assessments					
Writing reports and referral letters					
Other administration duties					
Meetings					
Other activities (specify)					

18. Who determines core pathways/management plans for service delivery in your workplace?

The Local authority ☐

The PCT ☐

The Schools ☐

Managers ☐

Yourself ☐

Other

☐

If other, please specify.....

Section B asked respondents about their clinical work with different client groups. Data from this is not included in the present paper and this part of the questionnaire is not included here.

Section C: Speech and Language Therapy in the Future

1. Do you see yourself working as a speech and language therapist in five years time?

Yes ☐

No ☐

If no, why?

2. Changes are imminent in services to health and education. Do you feel the speech and language therapy service for children will benefit from these changes?

Yes ☐

No ☐

Please explain your answer.

PLEASE PRESS XXX TO SUBMIT YOUR COMPLETED QUESTIONNAIRE.

THANK YOU VERY MUCH FOR YOUR TIME