Working together? The practice of educational psychologists and speech and language therapists with children with specific speech and language difficulties

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Abstract:
Meeting the needs of children with specific speech and language difficulties (SSLD) has recently been an area of public policy concern, because of the difficulties in securing speech and language therapy for children with special educational needs (SEN). There is a clear need for education and health service staff working together to support children with speech and language difficulties.

The present research involved case studies of six English local authorities (LAs), along with the eight speech and language therapy services provided by the relevant local health trust. They were chosen as examples of good practice in education and health services working together, on the basis of information provided during a previous national study. The purpose of the research was to explore the collaborative practice of educational psychologists (EPs) and speech and language therapists (SLTs) with respect to the education of children with SSLD.

This paper reports the views of 51 EPs and 120 SLTs, who worked in the case study LAs with respect to: collaboration; approach to assessment; provision; monitoring of progress; training and views on good practice. Despite the positive regard for collaboration expressed by both EPs and SLTs, their practice revealed little evidence of this occurring. Differences in approach, including the use of assessments for diagnostic purposes and the preference for inclusive as opposed to specialist provision, revealed important differences in conceptualisation between EPs and SLTs. The paper argues that these must be addressed so that collaborative practice by EPs and SLTs may be used not only to develop *good* practice but also to improve outcomes for children by *effective* practice.

Introduction

Children with specific speech and language difficulties (SSLD) have a primary language difficulty, which cannot be explained in terms of other cognitive, sensory or neurological impairments (Leonard, 1997). Prevalence studies suggest that the numbers of children with SSLD are substantial, about 5-7% at age 6 years (Law, Boyle, Harris, Harkness, & Nye 1998). Their primary language difficulties place them at risk of associated literacy difficulties (Botting, Crutchley, & Conti-Ramsden, 1998; Dockrell & Lindsay, 2004; Stothard, Snowling, Bishop, Chipchase, & Kaplan, 1998), poor academic attainments (Dockrell, Lindsay, Palikara, & Cullen, 2007; Snowling, Adams, Bishop, & Stothard, 2001) and social-emotional problems (Beitchman, Wilson, Brownlie, Inglis, & Lancee, 1996; Lindsay & Dockrell, 2000; Lindsay, Dockrell & Strand, in press).

This profile of complex special educational needs (SEN) of children with SSLD poses a challenge to their teachers (Dockrell & Lindsay, 2001) and parents (Lindsay & Dockrell, 2004), but also the key professional groups working with them from health trusts and education, namely speech and language therapists (SLTs) and educational psychologists (EPs). Educational psychologists play an important role with regards to all children with SEN including a crucial contribution to decisions about provision. Speech and language therapists are key professionals in relation to the provision for children with language and communication needs especially SSLD. They mainly work in health trusts, but are increasingly working in school settings supporting and conducting interventions (Law et al, 2000; Lindsay et al., 2002). Educational psychologists are mainly involved in the identification and the assessment of, rather than intervention with, children with SSLD (Law & Durkin, 2000). The information

provided by EPs' and SLTs' reports are key influences on the decisions regarding the appropriate provision for children with SSLD whether as a result of non-statutory or statutory assessments and the production of statements of SEN. Reports by EPs and SLTs also play a central role in the Special Educational Needs and Disability Tribunals (Special Educational Needs and Disability Tribunal, 2006).

The need for collaboration between these two professional groups has been identified by the Joint Professional Development Framework (JPDF) (I CAN, 2001), which highlighted the importance of multi-professional work between health and education. All levels (Foundation, Core and Extension levels) of the JPDF consider both language and learning needs of children and how current legislation, provision and services can be used to maximise educational opportunities for children with SSLD. However, as Law et al (2002) report, there is little evidence that recommendations in relation to collaboration that were outlined in the DFEE/DOH Scoping Study have been implemented.

Furthermore, collaboration between health services and education is a key element of recent government legislation and policy. *Every Child Matters: the Next Steps* (Department for Education and Skills, 2004a) and the Children Act 2004 put an emphasis on services from both education and health working together in the form of children's trusts in order better to meet the needs of children and young people. Current guidelines provide indicative directions for the development of services but there is as yet a lack of data on how such services work in a collaborative way to meet children's needs.

In addition to current policy legislation, a national study of provision of children with speech and language difficulties in England and Wales pointed out the importance of collaborative work between education and health services from national policy level, to the implementation of effective interventions in schools and clinics and children's homes (Law et al. 2002). Lindsay et al. (2005), who also examined the provision made by Local Authorities (LAs) in England and Wales for children with SSLD, identified collaboration as one of the key elements in developing inclusion for children with SSLD. McCartney (1999), however, identified a set of important barriers to collaboration between teachers and SLTs, namely the different models of collaboration adopted by schools and SLTs; social barriers related to the limited knowledge of these two professional groups regarding the working context of each other; structural barriers, such as timing and location; and process barriers.

As both government legislation and research have highlighted the importance of and the need for collaborative work between education and health, research to explore the views of EPs and SLTs in relation to the educational provision of children with SSLD provides evidence regarding current practice and which could inform future work. Dockrell, George, Lindsay, & Roux (1997) found significant differences between the views of these two professional groups. Most of the SLTs described as one of the most important aspects of the EPs' role that of providing a cognitive assessment, including non verbal ability, to contribute to diagnostic decisions on *specific* language difficulties as opposed to language functioning being in line with general cognitive ability. However, EPs did not wish to be seen as being limited to the role of providers of this type of data, viewing their contribution as much broader. On the contrary, EPs pointed to the unique contribution they can offer in relation to identifying appropriate

provision for these children and identifying their strengths. In a more recent study on a small sample of 15 EPs and 23 SLTs Dunsmuir, Clifford & Took (2006) also reported the differences in perceived roles of both EPs and SLTs in the assessment of SSLD as an obstacle to effective collaborative work between them.

'Good practice' – a systemic approach

There is much interest among education and health services in developing good practice (Kelly & Gray, 2000). A key element is collaboration. This has the potential to optimise communication between agencies and parents (Dyson, Lin & Millward, 1998). Law et al. (2000) also used collaborative practice as a marker for 'good practice' in developing provision for children with any type of speech, language and communication need. Collaboration has also been promoted in a range of government guidance for children with special educational needs including the Special Educational Needs Code of Practice (Department for Education and Skills, 2001). In our earlier study (Lindsay, Dockrell, Mackie & Letchford, 2000) good practice was generally exemplified by reference to processes, particularly collaborative practice, or structures, for example specialist provision or mainstream services. A range of processes including referral, assessment, and intervention were offered by LAs and health trusts as examples of good practice in their areas. However, while each of these may exemplify good practice, each is only one component in the complex system of multi-agency working to support the development of children with SSLD (Watson, 2006).

Our conceptualization of good practice is based on a systemic perspective of children's difficulties and how they can be addressed (Bronfenbrenner, 1979). This

systemic perspective was a major driver of the reconstruction movement in educational psychology in the late 1970s and 1980s (Gillham, 1978). Whereas schools were not always convinced of the benefits (Boyle & MacKay, 1990) there was also evidence of psychological services changing head teachers' perspectives in favour of such practice (Lindsay, 1995). Recently, Boyle and MacKay (2007) have found head teachers more positive about systemic practice characterised by engagement at the level of strategy. In the present context 'systemic' refers to the need for an analysis not only of, for example, what an SLT or teacher does with a child but how such actions fit within the total system of support. This requires examination of good practice at several levels. Firstly, at the superordinate level there is policy development by senior LA and trust managers and politicians. This sets the framework for practice (Radford et al, 2003). There is, of course, a higher level of national policy level which was not examined in the present study but was part of the focus of an earlier project (Law et al., 2000).

The next level concerns the implementation of these policies at service level, including the organization of EP and SLT service delivery and the roles of each professional. The next level concerns the school and includes its organization, how the outside professionals interact with it and how they deliver a service, including questions of prioritisation (Lindsay, 2007a). Next is the classroom level. This includes how teachers organize teaching for a child with SSLD; their use of teaching assistants (TAs); pedagogic approaches including special programmes and the use of support integrated into the mainstream curriculum, differentiated to meet individual children's needs; and the specific involvement of outside professionals in the delivery of support, for example the provision by SLTs of direct 1:1 therapy or advice to the

teacher/TA on delivery of a programme which they devise. Finally, the micro level concerns the interaction between child and the relevant adults, and the minute examination of learning per se (Lewis & Norwich, 2005).

Parents may input at several levels (Band et al, 2002). Some LAs and trusts have involved parents in policy development and at the national level individual parents and voluntary bodies (e.g. Afasic) have provided a parent's voice. At the child level there is often substantial involvement with the parents undertaking a large part of the programme of intervention, possible guided by an SLT or EP.

Finally, it is important to stress that this conceptualisation need not imply a simple uni-directional top-down approach with policy leading eventually to teaching interactions. On the contrary, it is essential to conceptualise systems as potentially reflexive. That is, the work at the child level is influenced by frameworks set at higher levels but this work may in turn influence the formulation of those frameworks, or lead to their modification. Frontline practitioners may contribute to a feedback loop and hence to policy development. Our interest is in identifying the different elements of good practice and how these relate, so complementing, energizing and supporting other elements *or* acting in conflict, destabilizing and undermining good practice throughout the system. No matter how good one element may be, in the latter situation the total system's ability to provide good practice is compromised.

The present study

The present study built upon earlier research which examined the educational provision for children with SSLD in England and Wales (Lindsay et al., 2005; Dockrell, Lindsay, Letchford, & Mackie, 2006). Pairs of LAs and their partner health trusts were selected as showing evidence of good practice on the basis of the typology of collaborative practice proposed by McCartney (1999), namely functional, structural, process and systems-environment. The overall project adopted a systemic approach, (Lindsay, Dockrell, Mackie & Letchford, 2002), investigating practice at different levels in the LA- health trust system. This included policy development by senior officers and politicians; the organisation and practice of EPs and SLTs, including their work in schools, and the parents' perspectives.

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The purpose of the present paper is to examine one level in our systemic model, focussing on the practice of SLTs and EPs in LA- trust pairs previously identified as exhibiting good practice in the provision of services for children with SSLD. The study investigated current practice by these two key groups of professionals and explored the evidence for collaborative practice. In particular, the study explored the extent to which LA – trust pairings previously identified as demonstrating good practice were characterised by shared understanding and collaborative practice between EPs and SLTs.

Method

Sample

Six local authority (LA)s and their eight health trust pairs were selected on the basis of evidence of good practice in provision for children SSLD (Lindsay et al, 2002). As there was a range with respect to degrees of inclusive practice it was judged important

to sample from LAs adopting various policies regarding provision for children with SSLD. Accordingly, the first criterion for selection was pattern of provision within the good practice LA-trust pairs, namely two high mainstream provision, two with high special provision (e.g. language units/integrated resources) and two intermediate between the other pairs. The second criterion was that there was evidence that the LA and its health trust partner(s) would work collaboratively together. The third criterion was that one of each pair would be urban and the other rural.

The questionnaire and interview data from the earlier study were reanalyzed to identify examples of good practice, generating 43 SLT services and 14 LAs. The need for pairings of LAs and SLT services reduced the possible sample. The final choice was therefore made from four 'high special provision' LAs, nine 'mixed provision' and three 'mainstream focussed provision'. Examples of good practice previously identified in each LA-trust pair were assigned to one of the four possible levels of collaboration proposed by McCartney (1999):

1. functional – remit, including aims and purposes, of the partner services.
2. structural – detailing ways in which the partner services interact and deal with relatively permanent and consistent aspects.
3. processes – dynamic aspects of service behaviour.
4. systems-environment – context of the communities and of the larger society in which a service is sited.

As there were no examples of systems-environment collaboration in the final list, the six case studies were selected to illustrate collaboration at the other three levels. A total of 125 EPs and 182 SLTs were identified in the LA- trust sample.

Measures

A questionnaire was designed for the EP and SLT samples with minor modifications to wording to make each bespoke for the relevant professional group. The questionnaires were designed to address the areas of practice identified in the earlier study as good practice, with particular reference to structural and process levels. These domains were checked with practitioners and other researchers to confirm their appropriateness and hence the construct validity of the instrument. The questionnaires covered the following areas: the nature of contact and discussion between EPs/SLTs; the nature of assessment; appropriate levels of speech and language therapy support for pupils in different types of provision; views on appropriate placement; monitoring of progress including annual reviews; training; and examples of good practice. Most items were rated on scales (e.g. strongly agree, agree, disagree, strongly disagree) with a small number requiring yes/no responses. (Copies are available from the corresponding author).

Procedure

Questionnaires were sent by post to all EPs in the six LAs and to all SLTs working with children in the eight partner trusts. All questionnaires were anonymised except for the LA or trust code letter. Respondents were requested to respond with reference to the current (i.e. sample) LA. A total of 51 EP and 125 SLT questionnaires were returned, response rates of 42.5% and 65.9% respectively.

These response rates are comparable to those in other studies of EPs and SLTs (Lindsay et al, 2002; Law et al, 2000). It is interesting to note that in all three studies, the proportion of SLTs that responded was consistently higher than that of EPs. It is

likely that this reflects the focus on children with SSLD. All SLTs working with children are likely to engage with this population and for a relatively substantial proportion of their time. This will not be the case for EPs in general given their much wider brief across all SEN. Educational psychologist respondents, therefore, are likely to reflect relevant members of their profession with respect to working with children with SSLD rather than the profession as a whole.

Results

Collaboration

There was no statistically significant difference between the reported levels of collaboration between EPs and SLTs when assessing a child referred for possible SSLD: $X^2(3, N = 157) = 3.09$, *ns* (Table 1). (All X^2 tests are two-tailed). Over half of each group of respondents reported either not collaborating or, if they did, doing so 'only a little'; only 6% EPs and 5% SLTs collaborated 'a lot' doing such assessments. A similar lack of collaboration was found for working in schools: only about a third of each group did this 'quite a lot' with few reporting this was a frequent occurrence ($X^2(3, N = 159) = 0.88$, *ns*). This lack of collaborative practice across the two groups as a whole was reflected also in the level of joint training they gave and received. In each case high proportions of EPs also reported this question was 'not applicable'. There was no statistically significant difference between the two groups on the level of collaborative practice when providing training on SSLD for school staff ($X^2(3, N = 143) = 6.48$, *ns*). However, those EPs that responded were more likely to report collaboration than SLTs with respect to receiving training ($X^2(3, N = 141) = 18.40$, $p < .001$).

<Table 1 here>

Assessment

The approach to assessment of children referred with possible SSLD taken by EPs differed from that undertaken by SLTs (Table 2). Both groups overwhelmingly reported that their purpose was to identify the child's learning needs: $X^2(3, N = 166) = 5.52$, *ns*. However, there was a statistically significant difference between the EPs and SLTs on the question of diagnosis: $X^2(3, N = 165) = 68.49$, $p < .001$. While 91% of SLTs also reported that they aimed to reach a diagnosis, this was the case for only 30% of EPs. Indeed, the difference was even more stark when comparing those who reported this occurring 'a lot': 46% SLTs: 4% EPs.

<Table 2 here>

About one in ten EPs reported using tests of non-verbal cognitive ability at least 'sometimes' with 47% reporting this occurred 'often' and 11% 'always' (Table 3). As expected tests of language ability, however, were used more often by SLTs: 96% stating this occurred at least 'often' and 63% 'always'. On the other hand, only 8% of EPs always used tests of language ability: $X^2(4, N = 168) = 67.72$, $p < .001$.

<Table 3 here>

Both groups reported that discussions with parents during the assessment process were common ($X^2(4, N = 168) = 2.76$, *ns*), although the fact that a quarter of EPs and a third of SLTs did not always do this is notable. Educational psychologists were

more likely to discuss the child with teachers in all cases (EPs 88%: SLTs 67%) but overall there was no statistically significant difference in this practice ($X^2(4, N = 168) = 0.29$, *ns*). However, observing the child in the classroom was more common among EPs ($X^2(4, N = 168) = 25.71$, $p < .001$) with 65% of EPs compared with just 24% SLTs reporting they always did this. Educational psychologists were more likely to report joint planning of assessment ($X^2(4, N = 168) = 16.47$, $p < .01$). However, the level was relatively low: only 14% of EPs and 7% of SLTs would plan with the other professional often or always and 27% of SLTs reported they never did this.

Provision

Most EPs and SLTs agreed or strongly agreed that pupils with SSLD were usually placed appropriately within the range of provision available (85% EPs: 77% SLTs, a non-significant difference overall: $X^2(4, N = 162) = 4.18$, *ns*) as would be expected given that these LAs were selected for demonstrating good practice. However, their views diverged when asked how they would prefer support to be made available. There was a statistically significant difference between EPs and SLTs with respect to placement in mainstream ($X^2(3, N = 158) = 11.76$, $p < .01$). Twice as many EPs as SLTs agreed or strongly agreed with more children with SSLD being placed in mainstream with support (55% v 27%) (Table 4). On the other hand, about three times as many SLTs as EPs wanted more children with SSLD in specialist provision such as units or resources (85% v 28%), $X^2(3, N = 159) = 48.19$, $p < .001$).

<Table 4 here>

Monitoring

Only 7% of EPs always wrote an update of progress for annual reviews compared with 66% of SLTs ($X^2(4, N = 154) = 51.68$, $p < .001$): EPs were more likely to report that they provided updates when requested (43% v 13%) or in accordance with

service priorities (33% v 21%). For both groups attendance at annual reviews was most likely to be governed by service priorities (48% EPs v 39% SLTs) or upon request (45% EPs v 23% SLTs). However, one in five SLTs (19%) always attended annual reviews whereas no EP reported this ($X^2(4, N = 152) = 16.70, p < .01$). In addition, twice as many SLTs would always scrutinize annual review paperwork to ensure intervention was taking place (50% SLTs v 24% EPs: $X^2(4, N = 150) = 10.22, p < .05$).

Training

Similar proportions of EPs (38%) and SLTs (46%) reported they had received training about working with other professionals to support children with SSLD over the time they had worked in the LA. Four out of five EPs who reported receiving such training stated it had been with SLTs whereas only 28% of the comparable group of SLTs reported having had joint training with EPs. More EPs rated their joint training very useful (56% EPs v 40% SLTs).

Views on good practice

At the end of the questionnaires, respondents were asked an open question:

> *Thinking of your experience of working with this LEA, please describe one or more examples that you regard as good practice in your work with children with specific speech and language difficulties. Please tell us why you view the example/s as good practice.*

By far the strongest theme across both professions (18 EPs, 60 SLTs) was collaboration as an example of good practice. In some cases the reference was general:

> 'Working with SLT to support pupils in mainstream school, where appropriate.' (EP 44)
>
> 'Reviews where both EP and SLTs work together with parents/staff to understand issues and plan appropriate intervention' (SLT 24).

The importance of close liaison was recognised:

> 'Close liaison with parents. Close liaison with schools and SLTs in specialist provision. Observation of child in light of speech and language experience'. (EP 48)

The importance of collaborative working comes through clearly from the EP who stated:

> 'From my work – the most satisfactory practice comes from meeting with the speech therapist along with school staff at the same time.' (EP 50)

Such views were expanded upon by another EP who gave explicit reasons.

> 'Liaising with SLTs and undertaking a joint assessment. This also involved working with parents and school staff to offer support and future strategies. [Good practice because] this improved my own and SALT professional knowledge and awareness of each other's skills and experience'. (EP 18)

Discussion

This study aimed to investigate the views of EPs and SLTs concerning their practice with and educational provision for children with SSLD. The results of the present research raise a number of key issues concerning models of good practice employed by EPs and SLTs working with children with SSLD, in particular the use of collaborative practice.

Firstly, our data show a clear lack of collaborative practice between these two professional groups. This was identified in relation to key aspects of the professional role of both groups, namely during assessment, while receiving joint training and when offering training on SSLD to schools. In the light of the current government

legislation, including Every Child Matters, which highlights the importance of collaborative work between education and health in relation to the provision of better services to children, these findings provide a worrying picture. For example, few EPs or SLTs reported joint planning of assessments, yet this can be more cost effective and acceptable to parents and children if duplication is avoided.

Speech and language therapists were much more likely to write updates of a child's progress for an annual review and were also more likely to be engaged in annual reviews. This area of practice has been problematic for EPs. At one time some EP services gave this activity a high priority as it was seen as an example of consultation and an effective form of input, but the number of children involved has increased the time allocation and it is now generally a less favoured activity. Yet, as with assessment, jointly planned updating a child's progress and engagement with annual reviews could be more efficient, cost effective and in the child's interest than independently organised action, or inaction. This lack of collaboration occurred in LA-trust pairs previously identified as having good practice for children with SSLD despite the positive regard with which it was held by many EPs and SLTs and the reports and research studies which have argued for the benefit of collaborative work between professionals (e.g. Dyson et al, 1998; Law et al, 2000). It is therefore important to question why collaboration was not more evident in the practice of these EPs and SLTs. It is likely that conceptual and practical factors serve as barriers and that more is needed to develop collaborative practice than exhortation and good intentions, or even research evidence supporting effectiveness.

Distinct differences in conceptualisation between the two professional groups are evident with regard to the purpose of the assessment. The large majority of EPs did not consider their assessment was intended to provide a diagnosis and only one in ten always used measures of non-verbal cognitive ability, while most of the SLTs considered diagnosis of SSLD as an integral part of their assessment practice. This result supports a similar finding comparing SLT managers and LA SEN officers (Dockrell et al., 2006).

Furthermore, SLTs were substantially more inclined to want more children with SSLD in specialist provision rather than in mainstream with support, the option which was preferred by the EPs. This reflects an important difference in views about inclusion with EPs reflecting a positive perspective for inclusive education well established in education among researchers and policy makers (e.g. DfES, 2004b). The SLTs may judge inclusion as inferior for children with SSLD than specialist provision (Dockrell et al, 2006). However, a more analytic and hence critical approach to the policy of inclusive education has recently become apparent, including the report of the House of Commons Education and Skills Committee (2006) on special educational needs, and a collection of reflections stimulated by Baroness Warnock's 2005 pamphlet (Cigman, 2007). While many parents seek inclusive settings, others argue that specialist provision is more appropriate. Furthermore, an extensive review has indicated that there is no clear evidence for the superiority of either mainstream or special settings (Lindsay, 2007b). This more recent evidence provides a useful basis for EPs and SLTs to develop a closer alignment of their views, so providing a more secure base for collaboration.

The second major barrier to collaboration concerns the practical difficulties resulting from different employer base (Kelly & Gray, 2000). These include different locations of work bases, conditions of service and administrative systems. These results are in line with the findings of a small scale study conducted by Dunsmuir et al. (2006), which also highlighted the limited opportunities for communication between EPs and SLTs. The development of SLT posts within LAs and schools has been beneficial but these bring with them other limitations (Law et al, 2000). Consequently, whatever the physical and administrative situation, it is necessary for EPs and SLTs to make their own arrangements to develop opportunities to develop joint planning and collaborative practices.

With the development of co-located multi-agency teams and of integrated children's services in general it is essential for both conceptual and practical issues to be addressed if practice is to be optimised (Booker, 2005; Watson, 2006). There is evidence of EPs and SLTs moving closer together in some respects including the use of consultation as a model of practice (Dockrell et al, 2006). This was promoted in the 1970s and 1980s by EPs on both theoretical and pragmatic grounds, reflecting both a reconceptualisation of the nature of children's difficulties and appropriate interventions, coupled with the need for a thinly spread profession to practise both effectively and efficiently. However, consultation models are neither simple to implement nor a panacea (Law et al., 2002; Lindsay, 2007a) and clearly require active monitoring from the professionals involved. The use of consultation as a major model of service delivery by SLTs in educational setting will need systematic training and evaluation in order to ensure the delivery of high standards. Implementation will also benefit from joint strategic planning of service provision, both structural and process-

related, at managerial level in order to develop effective multi-agency working (Law et al, 2000; Lindsay et al, 2005).

For collaborative work between EPs and SLTs to represent good practice, there is a need for the two professional groups to operate an integrated system of support for children with SSLD at different levels. At a *functional level* this will involve appropriately shared remit, aims, and purposes between EPs and SLTs. At a *structural level*, there is a clear need for consistent, relatively permanent joint structures in place regarding clear criteria for provision, and agreed and defined processes for the child's assessment. At a *process level* day-to-day collaboration and sharing of knowledge and skill systems through joint training and practice are necessary. At a systems-*environment level* it is important to include the child's 'world', the school and home, in the model of support.

Future work could usefully examine a wider range of LA-trust pairs. Furthermore, individual interviews with EPs and SLTs would allow for fuller examination of the issues raised by the results of the questionnaires. It is also important to build upon this study of good practice to examine *effective* practice between EPs and SLTs, characterised not only by the process of their joint working but also by the impact of their practice on the development of the children they serve.

Conclusion

Government policy stresses the importance of different professions working together. Children's services and the development of children's centres provide structures

which have the potential for facilitating collaborative practice. However, structural change is not sufficient. Effective collaboration requires both the full range of practical and conceptual issues to be addressed and resolved. Educational psychologists and SLTs have both the opportunity but also the responsibility to demonstrate how collaboration can deliver good practice for children with SSLD. To achieve this, however, there is a need for shared undertakings and critical engagement to reconcile different conceptual models in order that the particular strengths of each profession can be harnessed. As a result collaborative planning and practice, including assessment and intervention, can make optimal use of complementary skills. Such teamwork by EPs and SLTs, together with teachers, TAs and parents, when based on shared undertakings and jointly agreed practices, could provide a balance between the direct and indirect methods of intervention characterised by consultation and direct therapy. However, it is important to go beyond 'good' practice and to develop effective practice. While the former, as in this study, has focussed on structures and processes, effective practice is concerned with outcomes (Dockrell, 2005). The development of collaborative practice between SLTs and EPs is a step along the way to optimizing effective practice for children with SSLD.

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Table 1. Collaboration between EPs and SLTs (%)

		None	Only a little	Quite a lot	A lot	Don't know/ not applicable
During	EPs	6	47	38	6	2
assessment:	SLTs	16	42	32	5	5
Working in	EPs	9	55	32	2	2
schools:	SLTs	8	48	36	4	4
Receiving training	EPs	21	36	4	6	32
in SSLD:	SLTs	59	28	6	0	7
Providing training	EPs	23	43	9	4	21
on SSLD:	SLTs	43	35	14	1	8

Table 2 EPs' and SLTs' approaches to assessment of children referred with possible SSLD (%)

		None	Only a little	Quite a lot	A lot
Identify learning needs:	EPs	0	0	35	65
	SLTs	1	7	43	50
Arrive at a diagnosis:	EPs	24	46	26	4
	SLTs	1	8	45	46

Table 3 Methods of assessment of child referred with possible SSLD (%)

		Never	Rarely	Sometimes	Often	Always
Use standardised tests of non-	EPs	2	9	32	47	11
verbal ability:	SLTs	-	-	-	-	-
Use tests of language ability:	EPs	4	13	40	35	8
	SLTs	1	1	3	33	63
Discuss with parents:	EPs	0	0	2	23	75
	SLTs	1	2	7	23	68
Discuss with teachers:	EPs	0	0	2	10	88
	SLTs	1	0	5	28	67
Observe in classroom:	EPs	0	0	8	27	65
	SLTs	2	5	24	45	24
Plan assessment with EP/SLT	EPs	6	35	44	8	6
	SLTs	27	45	22	5	2

Table 4 EPs' and SLTs' views on where more children with SSLD should be placed in their LA (%)

		Strongly disagree	Disagree	Agree	Strongly agree
Mainstream with support	EPs	2	44	48	7
	SLTs	8	65	22	5
In specialist provision e.g. language unit/resources	EPs	7	65	24	4
	SLTs	3	13	58	27