

**COLLABORATIVE WORKING BETWEEN SPEECH AND  
LANGUAGE THERAPISTS AND TEACHERS OF THE DEAF**

**November 2007**

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# **COLLABORATIVE WORKING BETWEEN SPEECH AND LANGUAGE THERAPISTS (SLTs) AND TEACHERS OF THE DEAF (ToDs)**

## **AIM**

The aim of this position paper is to promote effective collaboration between SLTs and ToDs.

## **AUDIENCE**

The audience for this document is wide and includes

- SLTs and their assistants.
- ToDs and their assistants (e.g. Teaching Assistants (TAs)).
- Communication Support Workers (CSWs).
- Managers responsible for both professions.
- Children's Services' commissioners.
- Members of Cochlear Implant Centre teams.
- Deaf children and young people and their families.

## **INTRODUCTION**

In 2005, the British Association of Teachers of the Deaf (BATOD) and the Royal College of Speech and Language Therapists (RCSLT) decided that the guidelines drawn up in 1997 entitled "Guidelines for cooperation between Teachers of the Deaf and Speech and Language Therapists" needed to be reviewed in the light of a range of changes which had occurred affecting the practice of both professions and the changing climate in which they work. In particular it was felt that, as the process for delivering speech and language therapy and educational support for deaf children and young people had changed, it was especially important for managers responsible for such services to have access to a document clearly delineating the principles underlying the crucial importance of close collaboration between the two professions.

This paper is a response to that perceived need. A small working group comprising members of RCSLT and BATOD (see Appendix 1 for details) has met on several occasions since the end of 2005 to produce this document. During the process a range of examples of good and effective practice in which collaborative working was well established was gathered and considered. The result was the production of case studies. Further information was gained through the use of detailed telephone questionnaires with ToDs and SLTs. The case studies and questionnaires were then used as a basis to extract a range of universal principles of good practice which could be context-free. However, to illustrate many of these principles in context, specific documentation has been provided in the appendices. As these

documents originate from a variety of sources there are some differences in font and font size.

**These examples do not constitute recommended practice to be followed by all professionals in all circumstances.** In fact they are examples of different aspects of collaborative working which are successful for colleagues working together in particular settings. We hope that the examples will nevertheless be stimulating and helpful to those colleagues in the process of formulating and reviewing specific aspects of their own policy and practice.

In some cases contact details have been supplied with the examples so that colleagues can follow them up if desired in agreement with the author. In other cases the examples have been made anonymous.

This paper has emerged in a bottom up rather than a top down manner and cover settings from pre-school (immediately after newborn screen diagnosis) to Further Education (FE) and beyond. They can be applied in both urban and rural settings and be independent of communication methodology in use.

In this document the term 'deaf' has been used to refer to the full spectrum of deafness including those who are d/Deaf, deafened, hard of hearing and deafblind.

The term 'communication' is used to refer to the human exchange of information – both its receptive and expressive processes. The term covers all levels of language (e.g. social use, grammar, meaning, intelligibility) and all modalities.

## **FORMAT**

This paper includes a set of principles thought to be important for collaborative work, with real examples. Some of these examples are expanded in the appendices which also include other details referred to in the main document. Developing protocols for joint working is thought to be an important aspect of collaboration and so there is a focus on this aspect, with several examples provided.

## **PRINCIPLES FOR COLLABORATIVE WORKING BETWEEN SLTS AND ToDs**

### **Showing mutual respect**

This is indispensable to all collaborative working. It includes respect for:

- the role of each professional;
- the constraints of their working environment;
- each individual person and his or her individual characteristics;

- the abilities and skills of each professional and maximising these in working practice;
- each other's knowledge and an ability to admit those areas where knowledge is lacking;
- the training and experience of each professional.

### **Building an effective relationship**

This may require time and effort and involves empathy, openness and humour, and appreciating each other's work, expertise, opinions and culture. Active listening and other interaction skills promote the development of an effective relationship. It may also be useful, where relevant, to attend each other's professional meetings and engage in joint social activity associated with work.

#### **Example 1**

Both SLTs and ToDs attend social events organised for parents learning English as a Second Language (ESL) at the Birmingham Visiting Teachers Centre.

#### **Example 2**

SLTs and ToDs both attend social outings for extended families of pre-school deaf children in Staffordshire.

### **Discussing roles and responsibilities**

This is an essential part of building the relationship. It is important to acknowledge that there are a number of areas of overlap in the roles of ToDs and SLTs. Areas of overlap and specialist skills will vary according to the training and experience of the individual professional. These should be discussed in an open and constructive way. Such discussions should be seen as an opportunity to learn from each other and as a catalyst for developing positive working relationships. Conversely, being possessive or competitive about roles and responsibilities can be destructive.

In some services a 'keyworker' approach is adopted for the management of children, especially at the early pre-school stage, where it might be felt necessary to reduce the number of professionals visiting the home. Depending on circumstances, either the ToD or the SLT could be the keyworker. In such cases the priority and scope of the keyworker role needs to be agreed with the families as well as by both services and close liaison is vital.

## **Sharing information**

Although joint report writing might not be practical, it is essential that information be fully shared before reports are written so that they contain no proposals or comments unexpected by the other professional, particularly where changes of practice or approach are involved.

Findings from formal and informal assessments need to be shared so that all professionals have the fullest possible picture to inform discussions and meetings.

Sharing and developing materials together can ensure the best use of sometimes very scarce resources, whilst also providing an example of effective collaboration.

Information sharing could extend further and include sharing the fruits of academic and practical research in the field.

Other examples of information to be shared include target-setting, practical observations and reports from other professionals including colleagues from cochlear implant teams. It is essential that careful discussion takes place to avoid any mixed messages being given to parents, young people or other professionals concerning practice.

## **Working with others**

When working with colleagues from other professions it is important that both the ToD and the SLT ensure each other's involvement. Other professions would include Educational Psychologists, cochlear implant team workers, Audiologists and social care professionals.

## **Joint training**

Following initial training leading to qualification as a ToD or SLT, members of both professions have an obligation to continue their professional development. SLTs should refer to the RCSLT Clinical Guidelines (2005) and the Competencies Framework (2003). For information about training opportunities for SLTs and ToDs see Appendix 3

Where possible and appropriate, joint training has positive outcomes.

It is useful for SLTs and ToDs to attend the same training (both internal and external), where relevant, in order to be able to discuss its implications for joint practice. This could include attendance at conferences, seminars and special interest groups.

### Example 3

ToDs and SLTs from the Ear Foundation (Nottingham) both attended a residential weekend facilitated by an Audiologist experienced in working with the families of newly identified deaf children. For further details see Appendix 2.3.

It is also helpful for both professionals to be involved in the delivery of training – such collaborative working creates a very positive impression for other professionals.

### Example 4

A joint training event for mothers of young deaf children was jointly run by the Visiting Teaching Service in Birmingham and a SLT from the Ear Foundation. For further details see Appendix 2.4.

### Example 5

On a recent training event, an SLT and a ToD from the Ear Foundation (Nottingham) delivered a presentation about speech acoustics to a group of professionals. The SLT focused on the impact of speech acoustics on speech production, whilst the teacher reflected upon the importance of speech acoustics within a busy classroom.

### Example 6

SLTs from the Ear Foundation ran courses for parents of deaf children and a ToD gave input about language in the curriculum. For further details see Appendix 2.6.

## **Integrating management**

All aspects of management including assessment, target setting, implementation and evaluation should be integrated.

When deafness is diagnosed, it is beneficial for both professions to be informed and multi-disciplinary decisions made about level of involvement and working protocols. This will aid the effective management and deployment of resources in each specific setting.

When both professionals work side-by-side with the children (e.g. for joint assessments and team teaching), there are many benefits, including skill-sharing and relationship building. In most settings, time and resources do not allow for this to be possible for all aspects of management on a routine basis. However it is helpful for a pair of professionals to work side-by-side, even if occasionally, in order to learn from each other and develop new strategies for management.

Even if professionals are not working side-by-side, it is important that all aspects of children's management are integrated through joint planning, discussion, collaborative target-setting and joint evaluation.

Collaborative target-setting for school-aged children ensures that specific language-based targets integrate with targets relevant to the national curriculum.

Both professionals can contribute to a child's Individual Education Plan (IEP). There should be an agreed protocol about target-setting and evaluation.

It is of great importance that targets can be generalised so that they can be pursued in a range of settings and circumstances.

It is particularly useful if both professionals jointly write targets for areas not already covered in sufficient depth in the national curriculum.

#### Example 7

An SLT and ToD jointly wrote a document that gives examples of such IEP targets written for a range of children such as:

"By the next review Rahema will be able to name two strategies she uses when asked "What do you do to remember lists and instructions?""

For the full list of examples, see Appendix 2.7.

### Developing protocols

It is important to agree ways of working that suit the constraints and context of both services and all settings and to develop protocols.

Effective collaboration can be enshrined in a series of protocols or working documents which describe agreed ways of working essential for the professionals concerned but also for other professionals, managers and other stake-holders. Meetings of the local Children's Hearing Services Working Group (CHSWG) could provide a forum for developing protocols.

It is recommended that there be protocols or working documents covering most aspects of collaborative working. Various aspects are listed below and some of these are illustrated with examples of documents already in use:

- Domiciliary pre-school working including the rôle of the key worker.
- Use of Early Support materials.
- Family support principles in general (wider than Early Support)

#### Example 8

An SLT and ToD developed a protocol for managing the domiciliary service for pre-school deaf children in Islington that illustrates the three aspects above.

For further details see Appendix 2.8.



- Referrals.
- Hearing aid management.
- Liaison and planning opportunities – not leaving it to chance.

#### Example 9

ToDs and SLTs in Cheshire developed protocols for joint working that illustrate the three aspects above and Assessment (below). For further details see Appendix 2.9

- Assessment

#### Example 10

The Paediatric Cochlear Implant Programme at the Royal National Throat Nose and Ear Hospital, London developed a protocol indicating which professional carries out which assessment. For further details see Appendix 2.10

### Monitoring the Service

It is useful for both professionals to review regularly how they are working together, discussing what is working well and whether any changes need to be made – whether related to political, philosophical, cultural or resourcing issues. Suggested changes need to be raised at the appropriate level and not implemented without discussion. Difficulties need to be resolved in a constructive way rather than being seen as immovable constraints. It is important to do this at an individual level and also at a service level, with SLT managers and heads of teaching services, schools or units meeting to review and improve the service.

#### Example 11

At a special school in Camden LEA the head teacher and head of the specialist SLT service for deaf people meet regularly with the SLTs who work at the school to review the current service and discuss developments.

Regular meetings with heads of service and senior managers and other professionals will help to promote the effective delivery and development of the service (for example CHSWG meetings). As a result of these meetings, it may be necessary on occasion to consult other colleagues in the respective authorities who have strategic responsibility for service development.

### Extending collaborative work

This could include:

- Joint research projects.
- Joint bids for funding.
- Joint policy writing (e.g. communication policies).
- Further development of models of good practice.
- Developing information leaflets for families and school staff.

## CONCLUSION

Colleagues who work in a collaborative way have no doubt that such a way of working improves the effectiveness of the service that can be offered to deaf children and young people, as well as enhancing individual professional and personal development.

This paper is to be seen as dynamic and in no way set in stone. If you have any comments or contributions or pertinent illustrations of the principles described, please do not hesitate to send them to the BATOD Secretary at [secretary@batod.org.uk](mailto:secretary@batod.org.uk) and/or to [cpd@rcslt.org](mailto:cpd@rcslt.org) (putting "Update for BATOD/RCSLT Collaborative Working position paper" in the subject line). We will make these comments available, with the authors' permission, on our websites or in other publications. We expect this position paper to be reviewed at least every two years and would welcome new material at any time - particularly in view of the changing structures in which professionals are working.

## **Appendix 1**

### **BATOD/RCSLT Working Group**

The working group comprised representatives from the British Association of Teachers of the Deaf (BATOD) and the Royal College of Speech and Language Therapists (RCSLT):

Judy Halden (RCSLT)  
Edward Moore (BATOD)  
Alison Peasgood (RCSLT)  
Rachel Rees (RCSLT)  
Paul Simpson (BATOD)

## Appendix 2

### Examples of Practice

*These examples do not constitute recommended practice to be followed by all professionals in all circumstances. They are examples of different aspects of collaborative working which is successful for colleagues working together in a particular setting.*

#### 2.1

##### Example 1

Both SLTs and ToDs attend social events organised for parents learning English as a Second Language (ESL) at the Birmingham Visiting Teachers' Centre.

#### 2.2

##### Example 2

SLTs and ToDs together attend social outings for extended families of pre-school deaf children in Staffordshire.

Professionals from the Ear Foundation attended courses together, see below:

#### 2.3

##### Example 3

*Joint training with David Luterman.*

A small group of professionals, including both Teachers of the Deaf and Speech & Language Therapists were lucky enough to spend a residential weekend together to listen to and learn from David Luterman, an audiologist and professor with many years of experience in working with families of newly identified deaf children.

David's gentle and indirect facilitation of the group sessions allowed all participants to talk about their working lives and the challenges they face. This helped all those involved to appreciate each other's qualities and to reflect upon how we can work together and support each other. One of the delegates commented that one of the most useful things about the weekend was "meeting other professionals from different backgrounds and gaining so much support, wisdom and knowledge from them"

## 2.4

### Example 4

*Delivery of a parents' communication course.*

A joint training event for parents of young deaf children was jointly run by the Visiting Teaching Service in Birmingham and a Speech & Language Therapist from The Ear Foundation. The course focused on communication with the main aim being to help the parents think about how they could promote communication during the activities and routines of everyday life. The teachers and therapist worked together to plan and deliver the training and the teachers were able to follow up the sessions during their home visits and encourage the parents to take part in video feedback. One of the teachers commented that the "structured nature of the programme gave us new opportunities to discuss aspects of communication, reinforce strategies and evaluate progress in a way that is sometimes difficult to do in the home environment".

## 2.5

### Example 5

*Joint training on Speech Acoustics*

On a recent training event, an SLT and a ToD jointly delivered a presentation about speech acoustics to a group of other professionals. The SLT focused on the impact of speech acoustics on speech production, whilst the teacher reflected upon the importance of speech acoustics within a busy classroom.

## 2.6

### Example 6

*Joint training for parents around developing language*

Speech and Language Therapists at The Ear Foundation have run courses for parents of primary aged deaf children to talk about promoting higher level language skills. A Teacher of the Deaf, who also happens to be a parent of a deaf child, provided essential input to the programme by talking about language in the national curriculum, and how she promotes language development through games and activities at home. Her insights into how parents can support the work that goes on in the classroom were invaluable!

## 2.7 Example 7

### **Examples of Individual Education Profile (IEP) Targets written jointly by an SLT and a ToD on areas not covered in sufficient depth in the National Curriculum:**

#### **Listening/Auditory Processing/Memory**

1. By the next review Rahema will be able to respond successfully to two part instructions (e.g. “put the rubber in the box and give me the ruler”) when the person giving the instructions prepares her by saying “Listen carefully to this”.
2. By the next review Rahema will be able to name two strategies she uses when asked “What do you do to remember lists and instructions?”

#### **Vocabulary**

1. By the next review Jenny will have made at least 80 entries in a word book designed to record topic-related words with their associated definitions and example sentences in which they are used.
2. By the next review Amy will have made 10 entries in a word book designed to record verbs that look the same but that have multiple meanings, e.g. ‘take off’. This will include definitions of their meanings with example sentences.

#### **Speech Intelligibility and Grammar**

1. By the next review Jo will appropriately use the past tenses “lived”, “wore” and “worked” when describing the habits of people who lived in the past and will articulate “lived” and “worked” with a final /t/ consonant.
2. By the next review Ben will appropriately use at least 8 adjectives to differentiate 4 different materials: wood, glass, metal and fabric.
3. By the next review Billy will consistently and correctly use final /s/ and /z/ to mark regular plurals when naming, reading and repeating sentences.

#### **Social Skills**

1. By the next review Millie will have asked for clarification (e.g. ‘What does bungalow mean?’, ‘Please explain that again’) at least four times in one week in small group work with the Learning Support Assistant (LSA).
2. By the next review Sammy will have successfully relayed a message to an adult in another class/part of the school (e.g. “go and tell Mr B that Jimmy can’t go swimming today”).

#### **Independence/Self-help skills**

1. By the next review Al will consistently give the radio microphone transmitter to his teacher or the speaker in assembly.
2. By the next review Deepak will consistently choose an appropriate place to sit, in order to see and hear during carpet time/group discussion.

#### **Additional reference**

*IEP Writer 3*, Learn How Publications  
info@learnhowpublications.co.uk

## 2.8

### Example 8

**AToDs and SLTs developed a protocol for managing the domiciliary service for pre-school deaf children in Islington.**

**Islington** 

Primary Care Trust

#### **Speech and Language Therapy Service Domiciliary Service for Pre-School Deaf Children**

The Universal Newborn Hearing Screening pilot within Camden and Islington Community Health Services NHS Trust has been in place since the end of 2001.

The Speech and Language Therapy Service is one of the tertiary services that has input into this programme. The aim of the service is to develop the child's communication and empower the parents/carers to facilitate this process. This service works very closely with the Advisory Teachers of the Deaf (AToD) and also with the tertiary centres that assess the children's hearing.

A Specialist Speech and Language Therapist provides the therapy input. This is currently a 0.6 whole-time-equivalent (wte) post. At present the therapy input is adequate for the client numbers and it does not operate a waiting list. However, due to early diagnosis, the number of clients on the caseload is increasing significantly and is putting the service under stress.

The service works closely with the parents/carers of the children and the efficacy of this service is dependent on their co-operation. The parents/carers are equal partners in the therapy programme. They are provided with therapy input to facilitate effective interaction with their children, which in turn will develop the child's communication skills. Apart from the individual support and therapy, parents/carers are given access to a parent/carer group (organised jointly by the Speech & Language Therapist and the Teachers of the Deaf). These services also provide the children's nurseries with a staff training/information programme. The Speech & Language Therapist reviews her input into the family home and nursery as appropriate, updating programmes and information as required.

Parents/carers are provided with information about communication options and these are related to the child's hearing loss. The aim is to provide information and impartial advice in order to enable the parent/carer to make an informed choice about the preferred mode of communication.

The service delivery meets the guidelines of the Camden and Islington Trust and is also based on the NHS Clinical Governance framework. The standards of care are monitored and audited on a regular basis.



## Early Support Pack

Child's Name	Date of Birth
Parent's Name	ATOD:  SLT:

Information	Reference	Given by	Date given
Family File	ESPP5	<b>ATOD</b>	
Background Information	ESPP3	<i>ATOD</i>	
Info for Parents - Deafness	ESPP11	<i>ATOD</i>	
Overview card	ESPP6	<i>ATOD</i>	
Monitoring Protocol for deaf babies	ESPP29	<i>SLT</i>	
Fridge cards	ESPP32	<i>ATOD</i>  <i>SLT</i>	
Family Pack Box	ESPP1	<i>ATOD</i> <i>SLT</i>	
How to use this pack	ESPP7	<i>ATOD</i>	
Monitoring Protocol for deaf babies and children - Level 2 materials	ESPP31	<i>ATOD</i>	

## **Areas covered by Advisory ToDs/SLTs using the ESP in Camden and Islington Trust**

**Islington PCT + CEA (Cambridge Education Associates) @ Islington (Islington LEA)**

**Camden PCT + Children's Schools and families Service (Camden LA)**

### **Team**

The service for pre-school deaf/hearing impaired children is provided by a team based within both education and health services. The team currently consists of:

- Speech & Language Therapists
- Advisory Teachers of the Deaf
- Communication Assistant (0.6 wte CEA@ Islington only)

### **Client group**

The service caters for children aged 0-5 years who have a bilateral sensori-neural hearing loss. The teacher and therapist provide support within the child's home. If a child attends a nursery provision, the service is extended to encompass this placement.

Children with unilateral sensory neural losses are seen by SLTs from the wider SLT service

Children with complex needs are supported by the TOD along with the Child Development Teams (CDTs) and the SLTs within those teams are supported by the specialist SLT if requested. The TOD liaises with relevant members of the CDT, particularly the SLT, and works with them and the family to agree a package of support for the child.

### **Referral process**

- Following screening via the Newborn Hearing Screening Programme, babies who do not pass the screen are referred on to the tertiary referral centres (Nuffield Hearing and Speech Centre) for further testing. Occasionally referrals are also made to Great Ormond Street Hospital. Most of the latter group have more complex medical histories.
- The tertiary centre refers babies who are diagnosed with a hearing loss directly to the pre-school service. The referral is made on the same day by phone and paperwork follows. The Advisory Teacher of the Deaf is the first point of contact for the family following confirmation of the hearing loss.
- ToD to contact family within 24 hours of notification and visit to be made within 48 hours.

- ToD obtains family's permission to liaise with baby's Health Visitor (HV).
- If possible, initial visit is a joint one with ToD and HV.
- Following contact from the Teacher of the Deaf, the Speech and Language Therapy Service is mentioned (by the ToD) and involved as soon as the family is able/willing.
- First SLT visit is usually a joint one with the ToD.
- As ToDs do not work school holidays, the SLT service is contacted for newly diagnosed babies during this period and would make the first visit.
- For families where joint working has already begun, the SLT service is available to maintain contact during the school holidays if the family requests it.

## Supporting the Families

- Families are supported in their homes (preferably with both parents present at least some of the time).
- Support provided in the following ways:
  - Joint or individual visits made by ToD and SLT.
  - Individual visits are timed to enable one professional to visit families and monitor the situation for the other professional. Professionals then switch input: The following advantages / model are necessary to ensure continuity:
    - Ensure families are not overloaded with professionals in their home.
    - Enable professionals to use their time more efficiently and not duplicate input.
    - Professionals keep in close touch and highlight concerns relevant to the other half of the team while they are not visiting, so an extra visit can be provided if necessary or advice provided via the visiting professional.
- Input is also provided in nurseries that children may attend. This takes the form of:
  - Initial joint sessions – depending on need.
  - Joint sessions with SLT/ToD, key nursery staff, Special Educational Needs Co-ordinator (SENCO) and parents to set IEP targets.
  - Sessions delivered by SLT.
  - Sessions delivered by ToD - parents present at beginning of session and contacted at end of session for feedback about the visit.
  - Training sessions for nursery staff - jointly delivered - parents invited to attend.
- The Communication Assistant is supervised by the ToD and supports both the ToD and SLT:
  - by delivering packages drawn up by the two professionals in agreement with the family e.g. hearing aid use, developing listening skills, developing language.

- By providing input both to homes and to nurseries.

## Assessments

- ESSP family pack is used by both ToDs and SLTs with parents. The service has identified sections of the pack most effectively used/supported by each professional.
- Some assessments used primarily by ToDs with SLT supporting with information e.g.
  - IT-MAIS (infant-Toddler Meaningful Auditory Integration Scale).
  - Teaching Talking – Detailed Profiles (0-1), (1-2), (2-5).
- Other assessments used primarily by SLT with ToD supporting with information e.g.
  - Pre-school Language Scale 3 (PLS 3).
  - REEL (Receptive-Expressive Emergent Language Scale).
  - The MacArthur Communicative Inventory.
- Video analysis used by SLTs e.g. for Parent Child Interaction, Adult Child Interaction, PASS (Profile of Actual Speech Skills).

## Roles

Both ToDs and SLTs discuss **all** aspects of the child's development and support **all** aspects of each other's work. Each professional does, however, take a lead for different areas, coming together for discussion, input whenever necessary.

- General support:
  - Parents of newly diagnosed babies are provided with support to understand nature and implications of loss by both professionals.
- Hearing aids & radio aids (latter for nursery use only):
  - Setting up, understanding and use – ToD .
  - Establishing use – ToD lead with SLT supporting.
- Listening:
  - ToD starts as part of establishing hearing aid use with SLT supporting.
  - SLT takes lead at later stage to establish and work on listening skills with ToD supporting.
- Communication:
  - SLT takes the lead and is supported by the ToD.
  - Communication options discussed with families by both professionals.
- Speech work:
  - Thus far no direct speech work has been necessary, just advice provided. When necessary, the SLT would take the lead.
  - For children who move into mainstream reception class, the monitoring of their language development and speech is transferred to SLT from the Mainstream Schools Team.
- Nursery and education:

- ToD discusses local options for nursery placements with the parents, arranges visits and accompanies parents on visits so that pros/cons of each setting can be discussed.
- When choice of Early Years (EY) setting has been made and a place secured, ToD supports transition from home to nursery.
- Training nursery staff – ToD and SLT.
- Supporting Individual Education Profiles (IEPs) – ToD lead in organising but joint input .
- The ToD offers advice to family about relevant education options for the child in discussion with and supported by SLT .
- ToD arranges visits to different educational settings (as appropriate) and accompanies family so that the pros/cons of each setting can be discussed later.
- The ToD offers advice re the Statementing process .
- At transition SLT refers child to appropriate SLT service (e.g. mainstream SLT team, specialist SLT in special school, school for deaf or HIU).
- Liaising with hospitals, audiology clinics and other health and social services:
  - Lead professional ToD but both involved.
  - Both professionals equally involved for different aspects both pre and post cochlear implant.
  - Family give consent for ToD to liaise with other services and family is involved in (or kept informed of) all contact / discussions with other services.

## **CASE STUDY**

### **Background**

X was born in Oct 2000 by emergency caesarean section. He was identified via NHSP in Dec 2000. He was identified as having a bilateral moderate-severe sensory neural hearing loss with an overlay of glue ear. There is no family history of a hearing loss. However, recessive gene identified.

### **Support and Intervention**

The family was visited by the ToD following referral from the Tertiary Referral Centre when X was 10 weeks old (December 2000). Family gave permission for a referral to ToD.

ToD made contact by telephone with family and with the Health Visitor.

ToD visited family – Early January 2001 – ToD's first visit to family made jointly with Health Visitor.

ToD liaised with Consultant in Audiological Medicine, Audiologists and ToDs from Tertiary Referral Centre. During subsequent home visits, ToD clarified information about hearing loss with parents.

February 2001 (X four months old) hearing aids first fitted. ToD supported family with hearing aid management. X attended local music group and wore hearing aids to group.

After several visits from the ToD, the family agreed to a visit from the SLT for 'a chat and introduction only'. A joint visit was made by the ToD and SLT in March 2001. During this visit the family agreed to SLT input and visits were triggered.

In the early stages, both professionals visited the family separately but liaised very closely with each other, other professionals and the family. This was done in view of the very high anxiety levels demonstrated by the mother in particular. Both services provided support and information as the family came to understand the hearing loss, discussed prognosis, role of genetics etc. The joint services also encouraged the family to attend the local parent support group and provided information about the NDCS and the local NDCS groups.

The ToD took the lead in establishing hearing aid use and empowering parents to manage the hearing aids independently. Within approximately 4 weeks it was agreed with the family that the SLT would visit regularly to provide input while the ToD's visits decreased. However, the ToD continued to support the family around hospital visits, hearing aid use and glue ear as appropriate throughout. During phases when the ToD was not visiting, the SLT would monitor this aspect and provide feedback to the ToD.

The SLT offered ongoing blocks consisting of 6 –10 visits, which were spaced 1 - 4 weeks apart, depending on parental need at any point in time. The input was aimed at developing communication – eye contact, signing, listening skills etc. The ToD was kept informed throughout and as one professional completed a block the other took over to support. ToD liaised closely with SLT, kept in telephone contact with family and accompanied family to Audiology clinic for hearing and hearing aid reviews. On completion of SLT block of intervention, ToD resumed regular home visits (frequency of visits led by family). During home visits ToD discussed education options, local nursery provision and arranged visits to local nurseries including nursery at the Hearing Impairment Unit (HIU).

X started to attend a nursery at 2 years 3 months and nursery staff were provided with joint training by the ToD and SLT. This was to cover the use and care of hearing aids, and develop an understanding of language and communication development. X was given weekly input by the Communication Assistant (CA). Both the professionals, the CA, key nursery staff and parents also attended regular IEP meetings. The ToD identified additional funding for X to receive daily support in a small group and for an acoustic audit of the nursery. A radio aid was provided and the ToD trained parents and staff in its use. It was necessary for X to move to another nursery and staff training was once again provided by both professionals, while the CA supported the transition.

ToD referred family to Disabled Children's Team for assessment for home equipment e.g. TV loop. In February 2004 X had grommets inserted and the ToD, CA and SLT continued to support X at nursery. The SLT support at nursery was less intensive than the support provided for parents at home.

ToD supported parents with advice about local mainstream school options and facilitated parents' applications and visits to schools for a reception place for September 2005. In September 2005 X started in mainstream reception class. ToD and CA supported the transition to reception. The ToD provided training for reception staff about hearing aid /radio management, classroom strategies (with parents present) and provided training for entire school staff on deaf awareness, identification and strategies. ToD liaised with mainstream SLT who met X and family. X has ongoing support from ToD - visits for monitoring and advice and IEP reviews. As X's language development is now age appropriate, his speech, language and social communication skill development is monitored by an SLT from mainstream team in liaison with parents, school staff and ToD.

### **Progress: Language and Communication**

Parents used both signs and spoken language when communicating with X.

- **12 mths:** X was using repetitive babble, enjoying vocal games, using an approximation for 'mummy' and communicating non-verbally e.g. shaking head for 'no'.
- **18 mths:** glue ear had been diagnosed and was being treated.
- **2 yrs:** the communication assistant also started input and X's receptive vocabulary started to increase.
- **2.1 yrs:** by now X was also asking for his aids on waking and was starting to use 2 word combinations, and joining in action rhymes at the nursery. He used context effectively to understand communication in all situations.
- **2.5 yrs:** the nursery reported the use of 2 word utterances and jargon but at home X was using up to 4 word utterances alongside jargon. If the language proved too complex, X resorted to echolalia. Signs were now being used to support the learning of new words and were being dropped once they had been learnt.
- **2.8yrs:** a range of communicative intents was being used e.g. requesting, commenting, initiating communication. Receptively, X was able to respond to 3 word utterances without contextual support and longer utterances with context.
- **3 yrs:** X moved to a different nursery. Joint training was provided and regular IEP meetings attended. The SLT sessions were once again delivered into the home while the ToD monitored/supported progress in the nursery with the SLT making periodic visits. Signs no longer used to support language.
- **3.5 yrs:** digital hearing aids fitted and language, social skills and play continue to progress.

- **3.11 yrs:** language levels assessed formally using assessments standardised on the hearing population, and found to be age appropriate.
- **4.3 yrs:** joint visit made to discuss school choices – parents already having decided on mainstream education. Some normal non-fluency emerging and parents advised. This resolved itself with the appropriate management.
- **4.11 yrs:** transferred to mainstream schools service with Advisory ToD supporting. SLT support from service minimal. Being monitored in case need to support speech at a later date.

## **2.9 Example 9**

### **Protocol for Joint Working between Specialist Speech and Language Therapists and Teachers of the Deaf in Cheshire. (Draft doc 18/1/06)**

#### **Children with severe and profound hearing losses.**

##### **Referral procedure.**

- SLT and ToD will be notified by the Audiologists of newly diagnosed children with severe /profound hearing losses within 48 hours.
- ToD will respond and make contact with the family within 48 hours in line with existing practice.
- Within 12 weeks ToD and SLT will meet to exchange information about the child and family and a date will be arranged for a joint visit (The first visit by the SLT should always be a joint visit). This will allow the family time to identify some of their specific needs and enable the SLT to meet the agreed response time.
- During the summer vacation period a list of 'on call' ToDs and SLTs will be exchanged in order to ensure a joint approach.

##### **Family Support Plan.**

- The first Family Support Plan (FSP), (Early Support for preschool children), will be completed when the family is ready to proceed with it, and the ToD will explain the philosophy behind the plan. The plan will be shared with the SLT and any other agency involved with the child at the discretion of the family.
- Subsequent FSPs will be reviewed with the family, ToD and SLT and any other agency involved at least at 6 monthly intervals, with the approval of the family.

##### **Hearing Aids/Habilitation**

- SLT and ToD to advise on functional hearing and habilitation.



- ToD to advise on establishment of consistent use of hearing aids ,
- including cochlear implants and radio aids in conjunction with Cochlear Implant Centre and Audiologists. ToD will regularly test hearing aids/radio aids using a Test Box.

### **Liaison and Planning**

- Records of visits by the SLT/ToD will be written in the FSP (preschool) or in log left in nursery/school setting to ensure sharing of information.
- SLT and ToD to meet at least termly to discuss shared caseloads.
- SLT and ToD to agree with families the frequency of visits to families/placements and this can be decided at review of FSPs or Individual Education Profile (IEP) Planning Meetings.
- SLT and ToD will share and exchange reports, IEP's, Play plans and copies of assessments etc.
- E-mail/telephone to be used for contacts, information exchange etc.

### **Assessments**

- SLT and ToD will identify and agree formal and informal key assessments to be carried out, depending on the individual child. Professionals should not undertake assessments without prior agreement in order to avoid duplication and invalidation of test results. SLTs will undertake the majority of these assessments.
- SLTs and ToDs together to analyse video recordings with parental permission and share findings.
- If the child has a cochlear implant assessment findings should, with parental consent, be shared with the Implant Centre.

### **2.10 Example 10**

#### **Assessment carried out by the SLTs and TODs at the Paediatric Cochlear Implant Programme, Royal National Throat, Nose and Ear Hospital, London.**

Assessment is based on an integrated auditory perception battery devised and used by the team TODs and SLTs, plus additional assessment where required. This depends on the child, their provision and evaluation undertaken locally. Where possible, it is desirable that discussion with local therapists and teachers occurs to agree who undertakes which assessments at a particular post operative interval. Where children have additional needs, extension assessments may be required in addition to reflect emergent concerns as appropriate e.g. additional speech disorder.

SLTs tend to deliver the more speech and language based including assessments such as:

- Speech Intelligibility Rating Scales (SIR) – *Nottingham Early Assessment Package (NEAP)*
- Assessment of communication mode – CI teams UK.
- Clinical Evaluation of Language Fundamentals (Pre school and CELF - 3/4) – Harcourt Publishing.
- Checklist and Profile of Pre-Linguistic skills - McNab and Skinner.
- The Rosetti Infant-Toddler Scale (Linguisticsystems).
- The MacArthur Communicative Development Inventory.
- Profile of Actual Speech Skills (PASS) - *Nottingham Early Assessment Package (NEAP)*
- Phonological Analysis and Transcription of Audio-Visual Language (PETAL).
- Pragmatics Profile (pre-school and school age)– Dewart and Summers
- Test of Word Knowledge (TOWK) – Harcourt Publishing.
- Narrative assessment – in process.

TODs tend to deliver assessments related to listening/speech perception and school/curriculum based assessments, such as:

- Meaningful Auditory Integration Scale (MAIS)
- Listening Progress (LiP)
- Categories of Auditory Perception (CAP).
- Common Phrases Test.
- Common Objects Token Test (COT).
- Environmental Sounds Questionnaire/Test (RNID).
- Connected Discourse Tracking.

However both TODs and SLTs work closely together and frequently undertake joint sessions in order to facilitate a holistic and collaborative approach to assessment and management of the cochlear implanted child.

John Ford – Head of Advisory Teachers of the Deaf  
Julie Hare – Principal Speech and Language Therapist

### **2.11 Example 11**

At a special school in Camden LEA the head teacher and head of the specialist SLT service for deaf people meet regularly with the SLTs who work at the school to review the present service and discuss developments.

## Appendix 3

### Training Opportunities for SLTs and ToDs

#### Teachers of the Deaf

Information about training courses (both initial training and continuing professional development training) are available on the BATOD website at [www.batod.org.uk](http://www.batod.org.uk)

The website also includes a comprehensive calendar including details of courses run by a variety of other bodies including Deafworks and the Ear Foundation.

#### Speech and Language Therapists

Information about postgraduate courses in Deafness and Communication, for qualified Speech and Language Therapists, is available from the following sources:

City University, London.

Department of Language and Communication Science.

Advanced Clinical Studies (ACS) Diploma: SLT with Deaf People.

Diploma awarded by RCSLT.

[www.city.ac.uk/lcs](http://www.city.ac.uk/lcs)

Communication Skills Development (CSD) Consultants (Short Courses).

[www.csdconsultants.com](http://www.csdconsultants.com)

University College, London.

Department of Human Communication Science.

Continuing Professional Development Courses

[www.ucl.ac.uk/HCS/class](http://www.ucl.ac.uk/HCS/class)

(email: [hcs.class@ucl.ac.uk](mailto:hcs.class@ucl.ac.uk))

## Appendix 4

### Acknowledgements

All the professionals listed below have provided input to this position paper

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Children & Young People's Service  
Children, Young People & Families Directorate.

**Garside, Mary:** Head of Service for Deaf Children, Tower Hamlets.

**Haines, Glynis:** Specialist Speech and Language Therapist for Deaf People, Bucks PCT.

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**Inclusion Advisory Service/HI Team,** Camden Children Schools and Families - Hearing Impaired Service.

**Islington PCT - SLT service for the deaf** [CEA@Islington](mailto:CEA@Islington) Domiciliary pre-school working including the Rôle of the Key Worker and Use of Early Support materials.

**Kazi, Zeeba:** Principal Speech and Language Therapist, Camden Mainstream Schools and Deaf Services.

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**Varley, Mark:** Specialist Speech and Language Therapist for Deaf People, Camden Mainstream Schools and Deaf Services.

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Gagan, Lindsey

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Peasgood, Alison

Roberts, Lynne

Titterington, Jill

Williams, Kim

Worsfold, Sarah

**RCSLT Network of Special Interest Groups (Deafness) in the UK and Northern Ireland**

**The Implant Centre Speech and Language Therapists' Group (ICSALT)**

**Speech and Language Therapists in Bilingualism and Deafness (SALTIBAD)**

**ICTOD Implant Centre Teachers of the Deaf Group**

## Appendix 5

### Websites and Publications

#### Websites

##### **The British Association of Teachers of the Deaf (BATOD)**

[www.batod.org.uk](http://www.batod.org.uk)

##### **Deafness at Birth**

A website developed jointly by RNID/NDCS as a training and information resource for professionals who work with deaf babies and their families.

[www.deafness@birth.org.uk](http://www.deafness@birth.org.uk)

##### **The Ear Foundation**

A registered charity working to support children, young people and adults with cochlear implants, as well as their families and local professionals. See website for publications and training courses.

[www.earfoundation.org.uk](http://www.earfoundation.org.uk)

##### **The National Deaf Children's Society (NDCS)**

A registered charity working to support parents in helping their deaf child to develop his/her skills and abilities; providing clear and balanced information on childhood deafness, and also campaigning on behalf of deaf children and their families.

[www.ndcs.org.uk](http://www.ndcs.org.uk)

##### **The Royal College of Speech and Language Therapists (RCSLT)**

[www.rcslt.org](http://www.rcslt.org)

#### Publications

**The NDCS** publishes a wide range of leaflets, factsheets and professional publications covering a variety of topics related to deafness in childhood. e.g. Understanding Deafness

Information for Families

Hearing Aids - A Guide

Parenting a Deaf Child

The most recent is "Deaf Children and Speech and Language Therapy: A Guide for Parents". (NDCS)

There is also a Quality Standards (QS) series including:

QS in Paediatric Audiology

QS in Cochlear Implants

QS in the Early Years

Most of the publications are now available on the website and can be downloaded at no cost.

**The RCSLT** has produced several publications which provide guidance to clinicians and managers.

Clinical Guidelines (2005) lays out standards of care.

Communicating Quality 3 (2006) is the third edition of a handbook which gives guidance on best practice in service organisation and provision.

Competencies Project: Support Practitioner Framework (August, 2002)

Guidance for Speech and Language Therapy Staff for developing Knowledge and Skills Outlines (July, 2005)