The Case of Speech and Language Therapy

A working paper prepared for and by

Inclusion Ireland

September 2014

by

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With the support of

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The authors express their appreciation of the support of the Central Statistics Office in providing data used in this paper. We are grateful to parents in Laois and Offaly who supplied the results of their own local survey and to Down Syndrome Ireland for providing valued insights into the subject matter.

The views expressed in this Working Paper are interpretations and should not be attributed to any source or body cited or referenced.
Foreword

This working paper is part of a process of engagement with parents, therapists, academics and others to ascertain the extent and quality of speech and language therapy provision for children with additional support needs. Inclusion Ireland has been concerned for some time of the degree to which parents and family members have to fundraise and use their family income to secure therapy services that should be available through the public system.

The Bacon Report of 2001 called for an annual increase of 100 speech and language therapists per year from 2001 to 2015. In the intervening period Ireland has experienced a programme of austerity through which an embargo has been placed on the recruitment of therapists and other professionals. The Bacon Report in referring to the pre-2001 speech and language therapy levels stated that ‘after a period of tight constraints…it is necessary and desirable that supply should exceed demand by some percentage points’.

When the public system fails to meet the therapy needs of children and families there will be a growth in private and subsidised provision by charitable organisations. This is evident across Ireland. With over 4,500 children waiting or likely to be assessed as needing Speech and Language Therapy it is indisputable that the public system cannot meet the needs of thousands of children and their families. For many of those receiving a service the level of therapy is inadequate to achieve the desired clinical outcomes.

It is very difficult to obtain comprehensive data on publicly funded speech and language therapy services. There is little public data on the amount of therapists working in children’s disability services, the amount of vacant posts or the amount of therapy contact hours available.
The failure of the public system to provide adequate speech and language therapy to children with additional support needs is an enduring crisis for the families affected. There is a need to at least double the number of available therapists. Over the coming months Inclusion Ireland will continue the process of developing this working paper to identify the true extent and availability of speech and language therapy provision.
Key findings

A child’s access to speech and language therapy depends on where they live in Ireland. Cork South Lee and Wicklow have less than 100 children with complex needs for each speech and language therapist employed. By contrast Wexford and Donegal have more than 300 children with complex needs for each speech and language therapist employed. P. 30 & 39.

International research recommends caseloads of between 30-65 children for each speech and language therapist depending on the age and needs of the child. No health area in Ireland comes close to this recommendation (see Appendix 1). P. 30 & 39.

According to HSE figures collected by Progressing Disability Services for Children and Young People there is a national average of 162 children with complex needs for each speech and language therapist nationally (see Appendix 1). P. 40.

To meet international standards on appropriate caseload the amount of speech and language therapists working in children’s disability services would have to at least double from its current level of 283.3 to 565 (see Appendix 1). P. 40.

As many as 10% of speech and language therapy staff may be on one form of leave or other. This includes maternity leave, leave of absence or illness leave. The current embargo on filling posts means that many of these posts remain vacant. P. 14 - 15.

Access to speech and language therapy also varies within local areas. Laois Offaly Families for Autism surveyed their members on access to therapies. Participants reported an average of 5 speech and language therapy sessions over a 12 month period. At the same time 25% of participants reported
that their child had not seen a speech and language therapist in the previous 12 month period. P. 22.

Almost 3,000 children have been waiting more than 12 months for speech and language therapy. In addition a further 1,940 children are waiting for assessments for more than 12 months. P. 21.

Parent and family support organisations such as Down Syndrome Ireland, Laois Offaly Families for Autism and Clare Crusaders are either providing therapy or assisting their members financially to access private speech and language therapy. This therapy provision is financed through a combination of fundraising and a family contribution. P. 13, 20 & 22.

Speech and language therapists are centrally involved in assessments of need under the Disability Act 2005. At present assessments are taking on average 50% longer than the statutory timeframe to complete. Again, this varies depending on where you live. Of children assessed under the Disability Act, 80% require the services of a speech and language therapist.

The speech and language component of an assessment of needs varies in length. The National Disability Authority noted that in 2011 some therapists averaged 2.5 hours to complete an assessment while other therapists averaged 21.5 hours to complete an assessment. P. 21.

Extensive waiting lists for treatment and assessment, coupled with a trend of parents accessing private speech and language therapy are indicative of a system that cannot cope with demand. Families are making a significant financial sacrifice to obtain a service privately that they cannot obtain through the public system.

It is very difficult to obtain comprehensive data on publicly funded speech and language therapy services. Parliamentary questions are often answered in a vague manner in the Oireachtas, with a more detailed answer through
private letter to the deputy seeking the information. There is little public data on the amount of therapists working in children’s disability services, the amount of vacant posts or the amount of therapy contact hours available.

**In many areas of the country parents are accessing private therapists.** This is at a significant cost to the family budget. Speech and language therapy can cost from **€50 for 40 minutes to €100 per hour** for treatment. Private assessments, home visits and school visits cost more.

**Many parents and parent groups fundraise for speech and language therapy services** that should be available to children publically.

Research has shown that where speech and language therapy is offered in a mainstream preschool early intervention it is highly effective. Children, parents and staff benefit greatly from speech and language therapy being available in the preschool setting.
Progressing Disability Services for Children and Young People

Introduction

Extensive consideration and reflection has been given as to how best to improve the design, management and delivery of services for children with disabilities between 2009 and 2014. Focus groups, consultations, working parties and reporting groups as well as corporate bodies such as the National Disability Authority and the Health Service Executive have contributed substantially to the theme. These contributions are in addition to the ongoing work of the Health Research Board Disability Database Committees and the National Council for Special Education. The policy documents Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5-18\(^1\) and the work of Progressing Disability Services for Children and Young People articulate a good part of the ongoing reflection and policy formulation.

This short background paper prepared by and with Inclusion Ireland, offers a critical overview of the change process for services for children with disabilities through the microscope of one service: speech and language therapy. Founded in 1961, Inclusion Ireland is the national organisation for persons with an intellectual disability. However in developing the paper, special and additional account was taken of the views of Down Syndrome Ireland and Irish Autism Action who, like Inclusion Ireland, have broad national membership through county branch networks. The three organisations are concerned about therapies for children with intellectual disabilities or difficulties in learning through conventional approaches. The three organisations find themselves at one on many contemporary policy subjects.

\(^1\) December 2009
The rationale for preparing the paper was the considerable confusion expressed by parents of children with disabilities and some service providers as to why service delivery was changing or in official language – was being ‘reconfigured’ and what was to happen to specialist services. Speech and language therapy was selected as the viewing platform for the paper because it is a service highly valued and sought after by parents for their children.\(^2\) According to the Health Research Board National Intellectual Disability Database Annual Report, speech and language therapy was availed of by 2,079 children aged six years and under and a further 4,508 aged 7 to 17 years in 2012. This makes a total of 6,587. However this is an undercount since the National Intellectual Disability Database is limited to children and adults known or in contact with services and registered on their database. It also underestimates those who need an enhancement of their services. The Census of Population identified 14,744 children in 2011 with an intellectual disability and aged five to 19 years.\(^3\) While the Census (self described data) and the HRB data (third party sourced) cannot be compared, the difference between the two is surprisingly large. According to the CSO, more than 70 per cent of those with an intellectual disability also experienced difficulties in learning, remembering or concentrating.\(^4\) However, this does not accurately count all of the children in Ireland with ‘complex needs’. The HSE estimate that 4% of children have a complex need.\(^5\) Complex need means children who have ongoing health care needs. This 4% equates to 45928 children with complex needs. What all of these figures show is the disparity in official data.

\(^2\) HRB (2013) Annual Report NIDD Committee 2012, p.52
\(^3\) CSO, Census 2011, Statbank. Private household residents only.
\(^4\) CSO Census 2011 Profile 8 Our Bill of Health, Figure 29 and p. 22.
In a recent Dublin study parents were found to be a large source of referrals for speech and language therapy. The rise in demand for speech and language therapy is further underlined in the detailed study of the NCSE which noted that pupils with speech and language disorders made up 11 per cent of pupils in special classes in 2003; this proportion had risen to 15 per cent in 2008. Inclusion Ireland had also observed a considerable number of Parliamentary Questions were raised in the Oireachtas on the subject of speech and language therapy emanating from a variety of sources and regions during early 2014. This was occurring despite the availability of regional health forums to address such questions.

The paper takes six of the principles outlined by Progressing Disability Services for Children and Young People and attempts to test whether these principles are applied in the case of speech and language therapies.

By mid 2014, the programme for Progressing Disability Services for Children and Young People had established 60 geographically based multi-disciplinary teams. It is anticipated that a further 30 would be developed by the end of 2014. The plan involved allocating an additional €4 million to the programme which equates to 80 additional therapy and support posts including speech and language therapy.

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8 Minister Kathleen Lynch TD, Dáil Debates, 25 February 2014.
About Progressing Disability Services for Children and Young People (PDS)

The programme Progressing Disability Services for Children and Young People aims to achieve a **national and unified approach** to delivering disability health services so that there is a **clear pathway** to the services they need for all children regardless of where they live, what school they go to or the nature of their disability or delay.

Children should receive the health services they need **as close to their home and school as possible**. Some children may have their needs met by their local Primary Care services. An early intervention and a school age team will look after all children with **more complex needs** in a defined geographic network area, regardless of the nature of their disability. These teams will be supported by specialist services when a **high level of expertise** is required.

The programme also involves our partners in the education sector to ensure that we are working together to achieve the best possible outcomes for children.

The Health Service as a whole has to operate within the funding available to it and given the current economic environment, this has become a major challenge for all stakeholders, including the HSE, voluntary service providers, service users and their families. However we need to make the **best possible use of the resources** we have and if we work to get the structure right we will have strong foundations to build on.

HSE August 2013 Emphasis in text by authors.
1. **PDS: A national and unified approach to delivering disability health services to children and young people with a disability.**

This study identified seven different forms of access to speech and language therapy by parents on behalf of their children. The seven modes of access are:

1. HSE Primary care via a G.P. or local health centre/office and a follow up assessment
2. Direct engagement by a family with a private therapist or private therapy chain
3. Access to primary care and referral on to a privately engaged therapist for assessment
4. Associative parental provision such as through Down Syndrome Ireland or Irish Autism Action
5. In-house access through a service provider funded through s.38 or s.39 of the Health Acts
6. Referred through school
7. Combinations of modes one to six in varying sequences or simultaneously. A child may attend a private speech and language therapist while waiting for a primary care referral or appointment.

Modes 1 and 6 - accessing speech and language therapy via primary care or school is the mode of access most frequently cited in policy documents and in questions and answers in the Dáil during 2014. Services are also offered privately. Just under 100 speech and language therapists are on the register of the Irish Association of Speech and Language Therapists in Private
Practice all of whom have two years post graduate experience and are indicated in Modes 2 and 3.

Associative parental provision- Mode 4 - is a mode specifically identified in this study. It conceptualises the increasing number of parents of children who are not in residential care, live at home and who are supported by organisations such as Down Syndrome Ireland (DSI) or Irish Autism Action. Down Syndrome Ireland has 25 branches and employs itself or co-funds private speech and language therapists in 12 of its branches across 14 counties. These are Cork, Donegal, Kerry, Kildare, Laois, Limerick, Longford/Westmeath, Louth/Meath, Offaly, Tipperary, Waterford and Wexford. Their engagement includes full-time and part-time employment of speech and language therapists, fundraising to co-fund the costs of therapy and coordination of therapy services.

**Voices for Down Syndrome Galway** is the speech and language therapy side of the Galway branch of Down Syndrome Ireland and was established in 2005 by a group of parents. It is based inside the Department of Speech and Language Therapy at National University of Ireland, Galway and employs two senior speech and language therapists and in August 2014 advertised for further full time, part-time and contract senior speech and language posts. Students get firsthand experience of the work of speech and language therapy overseen by senior therapists.

Down Syndrome Ireland established a Special Interest Group (DSI SIG) for speech and language therapists in 2009. It has a membership of 160 therapists nationwide and aims to promote evidence based practice and
promote research and specialist training in the field. It is one of the ways that DSI provides services and resources not only to families, parents and service users but also to the professional community.⁹

**Clare Crusaders Children’s Clinic** describes itself as a wholly independent not-for-profit service providing speech and language therapy, occupational therapy and other therapies to children in Clare. They have offered treatment to more than 350 children with special needs in Clare. However the service states that it is getting phone calls seeking referral appointments from all over Ireland. The service does extensive fund raising and costs €225,000 per year to operate.

Dan Danaher, *The Irish Examiner*, 4.08.2014.

Mode 5 – in house provision by a service provider is the mode with which many parents are familiar, especially if they have older children and are long-standing users of a particular service provider well known in their local area such as the Daughters of Charity.

Mode 7 - is a combination of several modes used by parents. A child may receive four sessions of speech and language therapy though primary care and the parents then subsequently continue on with therapy with a private therapist. Protocols between therapists have been developed by the Irish Association of Speech and Language Therapists (IASLT) so that therapists know what each is providing to a single child.¹⁰

The Dublin Institute of Technology, 2012 Tallaght study of a specific programme observed that 74% of child referrals came from parents and the

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⁹ [www.dsi.ie/services/slt-sig/](http://www.dsi.ie/services/slt-sig/)

¹⁰ Information from DSI 2014
great majority of these were justified and the children were subsequently accepted for treatment. However this process was supported by information campaigns directed at parents. Such information campaigns are not typical, meaning that parents would not know of such services or how to refer their child to such a service.

Because parents are using a variety of modes of access to services, each mode is not representative of all people who use a service. Each is not a ‘discrete’ category. There would be double counting if modes were added together. There would be undercounting if just one mode were to be a proxy for people accessing services. A child on the waiting list for one service may be receiving treatment from another. Conversely a child on a waiting list and assessed for treatment under primary care could be waiting up to a year in some instances for therapeutic sessions.

The comprehensive or unified character of a service depends on a supply of clinical practitioners and an administrative system which incentivises rational deployment. The supply of speech and language therapists has a weak relationship to demand for services. The four schools 11 who provide education to speech and language therapists to a qualified standard, supply them to a market where the largest employer – the HSE – has a moratorium on new recruitment and a policy of non-replacement of staff absent due to maternity leave, parental leave and sickness leave. Since speech and language therapy is a highly feminised profession with an estimated 90% of graduates being women, the moratorium falls particularly hard on therapy. It has been estimated that at any one time there are 10% of therapists on maternity leave, illness leave, or some other form of leave12. This leave is not evenly distributed across health service areas.

11 University of Dublin Trinity College, University of Limerick, NUI Galway and NUI Cork
“My son was getting a great service and then the speech and language therapist went on maternity leave. She wasn’t replaced and there were no more appointments for 11 months”. Focus group participant.

**Occupational Therapists, Speech and Language Therapists and Psychotherapists and other therapists** (1)

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Person(s)</th>
<th>At work</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Employer/own account</td>
</tr>
<tr>
<td>2006</td>
<td>5,346</td>
<td>2,030</td>
<td>3,208</td>
</tr>
<tr>
<td>2011</td>
<td>7,579</td>
<td>2,853</td>
<td>4,348</td>
</tr>
</tbody>
</table>

Source: CSO, Census 2006 and 2011 Volume 3 Table 2 Code 347 (1) excluding Physiotherapists and Psychologists

Some 838 whole time equivalent speech and language therapist’s work as employees either directly for the HSE or in HSE funded organisations (see Appendix 2). Of these 838 posts it was estimated that in 2012 there were as few as 283.3 whole time equivalent speech and language therapists working with children’s disability teams\(^\text{13}\) (see Appendix 1). The number of therapists actually treating children is lower. As noted, 10% can be on leave at any one time and 7% of therapists are in management roles.

\(^{13}\) Progressing Disability Services for Children and Young People National Local Implementation Group Mapping, Health Service Executive, 2012.
Between the Census periods of 2006 (pre crisis) and 2011 (post crisis) the numbers of persons holding professional qualifications increased in the category which encompasses speech and language therapy. Numbers rose and supply of professionals increased. Third level education is usually a strong barrier to unemployment but this is not the case with some professionals. The unemployment rate rose from 1.8 to 4.8 per cent over the period. In 2011, some 361 allied health professionals including speech and language therapists, physiotherapists and others, described themselves as unemployed. In addition the proportion of employees among the professionals remained constant at 60/61% of all at work. This means a substantial proportion of professionals - 40% - are in the private sector as sole trading professionals, or self employed or employer of others or have emigrated.

With a surplus of supply, wages for speech and language therapists in the HSE fell partly due to the provisions of Financial Emergency Measures in the Public Interest Act (FEMPI) first introduced in 2009. Speech and language therapy remuneration in the public service has a 12 point pay scale. The mid-point fell from €45,993 at the start of the crisis to €38,964 in 2013. Some of the supply of non-employee speech and language therapists have emigrated.

Among the self-employed on a sessional basis, an unknown number are at risk of not operating under a senior supervisory therapist. Continuous professional development becomes difficult to enforce and in-house tutors are now negligible in HSE employment since there is no new recruitment. Young graduates establish themselves where it is most convenient to

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14 Consolidated Pay Scales. HSE.
themselves or their households and not as part of a programmed deployment using human resources to best effect.

Chart 1

<table>
<thead>
<tr>
<th>Professionally Recognised Courses in Speech and Language Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognised overseas qualifications</td>
</tr>
<tr>
<td>Graduates</td>
</tr>
</tbody>
</table>

1-2 years supervision by more senior employees

No openings in the HSE/main employer moratorium on recruitment and replacement

Emigrate

as self-employed or employee of private company/chain

Move directly into private sector

The provision of speech and language therapy is developing in an asymmetrical way with a variety of provision emerging outside the core of planned geographically based primary care. **The fragmentation has reached a level where one can say that yes there is provision but it is not functioning as a service.** The supply of professionals is establishing itself according to market criteria. The level of feminisation of the profession is such that absences due to reconciliation of work and family life fall disproportionately on provision since such absences cannot be temporarily replaced.

2. **PDS: A Clear Pathway for all Children**

The clear pathway for all children who need services might be described as several pathways and some cross roads. It is recognised that creating a clear pathway will be challenging and involve ‘a cultural change required of
individuals and teams often multi-agency to implement it.\textsuperscript{16} This was the view in 2009. We are now five years on. A clear pathway to professionals and social service staff may be very foggy for the public and any parent who uses services with their children. The first step for many parents, and advised to them by experts, is to get an assessment of need of their child. This is a contentious area and this paper will restrict itself to a few aspects of the process.

A formal assessment of need is required by schools in order to obtain additional resources to provide reasonable accommodation for children with disabilities to learn and manage themselves in the school environment. This practice is governed by the Department of Education and Skills.\textsuperscript{17} While it is the view of the HSE that there should be flexibility in this area, in practice absence of professionally certified proof of a disability can reduce a child’s chance of obtaining specific support resources in school. It is the view of the NDA that some parents then seek assessment of need from the HSE to supply a ‘certifying document’ to schools\textsuperscript{18}.

“You go to private speech and language therapy as there is huge waiting lists for HSE therapists. Parents do it out of guilt. We know that therapy is effective when children get it early but there is a year of a waiting list”.\textbf{Focus group participant.}

“You are scared and will do anything to ‘fix’ your child. You know how important early intervention is. I borrowed €450 from my parents to pay for speech and language therapy”.\textbf{Focus group participant.}

Under Department of Education and Skills Circular 02/05 children who have an intellectual disability and fall below a given threshold of a measured test of intelligence and appear to require speech and language therapy, may be refused such therapy in an assessment of need where the results between the two assessments do not pass a given ratio to each other. The outcome of this is peculiar in that children struggling with an intellectual disability arising from Down Syndrome can fall between the cracks. This group of children are often seen as being ‘to bad’ to be seen by the primary care team but ‘not bad enough’ to be a priority by the specialist disability team.

For children on the Autism Spectrum, multidisciplinary assessments of need are commonplace and can take a considerable time to complete.

Waiting lists for assessments of need under the Disability Act 2005 have been building up. In 2012, about 20% of assessments were completed on time with considerable variation across the country. Parents have a statutory entitlement to an assessment of need under the Disability Act, 2005 if their children were born after 2002. The question arises of how many assessments are being requested, conducted and reported on under Section 13 of Part 2 of the Disability Act 2005. This should be easily accessible from statutory reports under the Disability Act, 2005. To date, reports have been compiled for the years 2007, 2008-2009 and 2010 and were published by the HSE.¹⁹ A combined report for the years 2011-2012 and for 2013 were in compilation in April 2014. As fast as waiting lists reduce, the growth in the population of children on whose behalf an assessment is sought, wipes out the reduction and the list reverts to its original length.

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¹⁹ Kathleen Lynch TD replying on behalf of Minister of Health James Reilly TD to question put by David Staunton, T.D. on 30.04.2014.
To address the question of waiting lists, the HSE commissioned private assessments between 2012 and 2013. Some 1,794 private assessments were undertaken; the majority in Dublin North East (933) and in Dublin Mid-Leinster (673). Some 163 of assessments were commissioned from the independent multi disciplinary centre – Solas (Dublin) – in South Tipperary and Wexford.

The Solas Centre in Dublin is a standalone independent centre under the auspices of Irish Autism Action and provides multidisciplinary assessments and pathways to speech and language therapy. Initially, parents who could afford to pay did so. Since the economic downturn Irish Autism Action has heavily subsidised this service.

Both DSI and SOLAS are a framework for specialist expertise in intellectual disability and Autism Spectrum Disorder. The expansion of the knowledge base through exposure to large numbers of young clients/service users enhances speech and language specialisation.

In an interesting report commissioned by the HSE, the National Disability Authority carefully examined the factors giving rise to the waiting lists, their local impacts and their uneven spread across the country. Among the factors identified were varying appreciation of what was actually required of an assessment of need under the Disability Act 2005 and a clash of practices and perspectives between the HSE and the Department of Education and Skills in terms of the assessment of need as a key to the gateway to disability services.

The Report found that:

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20 Reply of Ms Marion Meany of HSE to Stephen Donnelly TD on 11.07.2014 re: PQ 27574/14 and 27575
The average time to make an assessment of need in speech and language therapy could range from **2.5 hours to 21.5 hours**.\(^{22}\) Local integrated teams made assessment a smoother process. A statutory instrument in relation to the level of assessment required would free up much needed time for speech and language therapy treatment.

This report also noted that therapists could spend up to a day writing up an assessment report but with the appropriate administrative support would be able to spend more face to face time with children.

Waiting and treatment lists for speech and language therapy are not collected by age. In February 2014 7,798 persons - had been waiting less than four months for speech and language assessments; 6,952 had been waiting longer than four months. Of those waiting for treatment (15,700) about 46 per cent had been waiting for less than four months. In addition, **2983 children were waiting longer than 12 months**.\(^{23}\)

### Speech and language therapy provision in Laois Offaly

In a survey of members Laois Offaly Families for Autism (LOFFA) reported that 75% of respondents had seen a speech and language therapist in the last 12 months. They averaged 5 appointments each in the preceding year. However, **25% of children did not see a speech and language therapist in the preceding 12 months**.

Participants reported an average wait of 2 years for speech and language therapy. Many special schools and special autism classes in Laois and Offaly had their speech and language provision removed.

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\(^{22}\) p.139.

\(^{23}\) HSE reply to Parliamentary Question of Deputy Colm Keaveney of 4.02.2014.
The average time between referral to early intervention services and a diagnosis of autism was 1 year and 3 months.\textsuperscript{24}

Parents are voting with their feet. LOFFA report that they provide a subsidy to parents who access speech and language therapy privately. They have paid out more in subsidy in the first 6 months of 2014 than in the entire year of 2013. Progressing Disability Services for Children and Young People has been implemented in this period.

The LOFFA survey estimated that families spent on average €1000 privately across all therapies in 2011.

To obtain an assessment of need, parents ideally apply themselves to one of 32 local health offices.\textsuperscript{25} A local health office is a somewhat unknown entity.\textsuperscript{26} The term health centre is more familiar. Local health offices are distributed across the country and from the Census 2011, map in some counties the local health office is quite far away from people’s homes. A map showing a thirty kilometre range equidistant around each local health office shows that parts of the country are outside the 30 kilometre range (see map on page 49).

An assessment of need under the Disability Act 2005 can be made at a local HSE health office. The precise addresses of the 32 local health offices are not on the HSE website in some cases. About 18 per cent of the population have no access to a computer or do not have internet/broadband. These

\textsuperscript{24} Laois Offaly Families for Autism, Survey on Service Provision in 2013, 2013.
\textsuperscript{25} However in the case of children presenting at school, parents in 2011 were advised to address a SENO Circular No. 0020/2011 to the Management Authorities of National Schools on the Assessment of Need process under the Disability Act 2005.
\textsuperscript{26} An anecdotal query of professional colleagues as to what a ‘local health office’ was drew no correct answers.
households are generally the more isolated and without anyone working.\textsuperscript{27} People who use a particular service or require an assessment of needs are presumably expected to phone, as the phone number is provided. Negotiating services by phone is a skill not available to all. This fact appears to be underestimated by decision makers. \textsuperscript{28} Alternatively, an application for an assessment of need may be made by an advocate. However this involves using a different service: the Citizen Information Board, National Advocacy Service under a different department of government. Currently, the National Advocacy Service does not offer an advocacy service to persons under 18. Besides a distance to travel, some families are also disadvantaged by means of access.

Assessment of need completed in less than 4 months is one of the metrics measured monthly and used by the HSE as a form of performance indicator. In 2012, nine of the 32 local health office areas had completed assessments of need in less than four months in 97 to 100 per cent of cases. The remaining 23 took longer than four months. Dublin South West and West, Carlow /Kilkenny and Kildare/West Wicklow had the longest waiting times (see Chart 1 page 42).

The numbers of applications from parents or guardians of children for whom an assessment of need is sought is generally increasing year on year, such that it is difficult to envisage how the waiting lists for assessment can be addressed within existing resources. The average time to complete an assessment of needs is 8.9 months or almost 50\% longer than set out in the Disability Act 2005. Many health areas perform very well but others completed no assessments within the statutory timeframe of the Disability Act. The situation is a postal lottery.

\textsuperscript{27} CSO statistical release, 20 December 2013, Information Society Statistics – Households - 2013
\textsuperscript{28} See leaflet Assesing your child’s needs - Disability Act 2005. HSE. No date.
Table 2  Numbers of children for whom an assessment of need was sought 2007-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Applicant Numbers</th>
<th>% increase on previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>5,568 est.</td>
<td>20 estimated</td>
</tr>
<tr>
<td>2013</td>
<td>4,261</td>
<td>22</td>
</tr>
<tr>
<td>2012</td>
<td>3,505</td>
<td>5</td>
</tr>
<tr>
<td>2010</td>
<td>3,100</td>
<td>23</td>
</tr>
<tr>
<td>2009</td>
<td>2,525</td>
<td>0</td>
</tr>
<tr>
<td>2008</td>
<td>2,535</td>
<td>122</td>
</tr>
<tr>
<td>2007</td>
<td>1,138</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: 1-3 Extracted from reply of Ms Marion Meany for HSE to Stephen Donnelly, TD of 11.07.2014. p.1. PQ 27574/14 + 27575/14. 4-7: NDA (2012) Table 1

Speech and language therapy is the most common service required by children who undergo an assessment of need, with some 80% of children assessed requiring this service\(^\text{29}\). Given the length of time on waiting lists (for assessment and treatment), parents not surprisingly start looking around for alternative solutions. International research indicates that early intervention at a young age by a speech and language therapist\(^\text{30}\) has the most benefit for the child. Parents are very aware of this.

**All children - early Childhood**

With the introduction of a free year of early childhood education, the question arises of the rights of young children with disabilities to avail of this educational year. While theoretically available, there is no mechanism for public or private providers of early childhood education to supply reasonable


accommodations as required by the Equal Status Act 2000-2008, Education Act, or EPSEN Act. At present an estimated 47% of 3,401 services surveyed by Pobal on behalf of the Department of Children and Youth Affairs, have at least one child with a disability in attendance. The largest numbers of children have (1,302) autism or have an intellectual or learning disability (1,380). The NDA study notes that as many as one fifth of applicant children with disabilities may be turned away from mainstream preschool. The response of Government has been to concede that there is a problem and to mention ‘flexibilities’ in the scheme such as permitting children with disabilities to enrol for the early childhood year with an ‘age waiver’. Another suggestion is that when they are overage, to attend over two years instead of one. Some service providers offer ‘special’ pre-school facilities for family users of their services. This varies greatly across the country.

Among children benefiting from the work of HSE funded early intervention teams, speech and language therapy was one of the most commonly availed of services. As noted earlier, 80% of children who undergo an assessment of need require the service of a speech and language therapist.

**Current government position on this issue is:**

While the HSE has no statutory obligation to provide supports for children with special needs wishing to avail of the free preschool year, it works at local level and in partnership with the relevant disability service provider to address individual needs as these arise.

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34 Kathleen Lynch, TD Minister of State, Dail, Topical Issues, 25.02.2014, p. 31.
Kildare Branch of Down Syndrome Ireland’s Own Early Development Group

Kildare parents and young children have an opportunity to avail of a special service for children aged from a few months up to five years old.

Young children and their mothers can attend a special playgroup once a week from 10 am to 12 am. One group runs for very young babies and toddlers and a second group runs for children aged two years to five. Children begin to learn LAMH signs and learn listening skills and sounds. Dolls are used to practice the names of clothing. Children learn to sit in a circle and sing songs while making signs. Making eye contact, taking their turn and interacting with other children are just some of the skills that the children are exposed to prepare for a successful pre-school experience.

Older children get a chance to sit at a table, find their lunch box and choose a coloured plate.

Every second week there is a talk or lecture for parents – often mothers. While children are at playgroup, mothers can get a chance to have a much appreciated cup of coffee. During their playgroup time, some children will attend speech and language therapy in a separate room.

Source: Nicola Hart DSI and kildaredownsindrome.thecroftcave.net

At present there is a cross departmental group from the Departments of Health and Education working on this issue to determine which department is responsible for supporting children to attend preschool placements.

Given the observation of the Growing Up in Ireland study and Ward (1999) that speech and language disorders are better treated early, this is a priority...
area. Children with a disability need to be engaged in preschool placements and receiving a speech and language therapy provision. The effectiveness of speech and language therapy delivered in a preschool or school setting has been well documented. Speech and language therapy enables education, which in turn enables further speech and language development which enables a person’s full participation and inclusion in society. In this context the importance of the development communication through speech and language therapy cannot be understated as it enables a person’s full development.

Since services for children with disabilities have not been transferred from the Department of Children and Youth Affairs or agencies under its auspices such as the HSE, young children themselves remain the responsibility of the HSE and arguably so, even where a service is under the agency Pobal or a programme of Early Childhood Education.

It is unlikely, despite the best efforts and good faith of the HSE, that the waiting lists for assessment of need or speech and language therapy can be substantially reduced in the short term.

**Marias Story**
My daughter is a typical child of austerity I guess.
Here is my daughter’s experience to date of a shockingly dreadful failed system. She was born in 2005 and is 9 years old.

**2006** In the system (as they say) since referral eventually at 18 months. She has no words. No speech therapy. Introduced to our first HSE speech and language therapy (SLT) waiting list.

**2007** Finally got Fragile X, Autism diagnosis at 30 months. That was a battle in itself.
Placed on waiting list with early intervention team. No services.
2008 No services.

2009 From 4/5 years of age some speech therapy received on occasion following assessment of need. PECS was not offered by SLT as an alternative means of communication.

2010 Home support worker came to the family home for one hour to teach us Lamh (sign language).

2011 Started school in an autism unit; no therapy supports in place. On yet another waiting list for local autism services.

At 6 years of age some SLT offered in school following several PQ's being raised and intervention by my local TD. Some children in autism unit received services. Some children who didn't fit into a "mild" category and needed more services still to date receive nothing.

2012 At 7 years of age moved to special school naively thinking there would be regular access to clinical supports. School SLT was on maternity leave; no cover or replacement offered. No services.

2013 No services.

2014 No services.

I am currently waiting to see this new model of Disability Services in action in my area. My daughter has yet to meet one member of her new team.

3. PDS: Close to Home

Public policy intends that all children with service needs should be able to avail of services on a local geographic basis close to home regardless of their
disability, their school location or the location of a service provider from whom their family is receiving services on the child’s behalf. ‘There will be equity and standardisation in how you receive and experience services and supports no matter where you live in Ireland.’ This was an important recommendation of a Working Group taking the long-term perspective. This is a relatively new goal of public policy in relation to disability. Access to therapeutic services has up to now frequently depended on their availability through service providers funded under section 38 or section 39 of the Health Acts. The move intended is for area-based geographical teams composed of professional therapists from several disciplines. This implies that various service providers will no longer be funded necessarily to provide therapeutic supports. Sixty area-based teams had been established by mid 2014.

Mapping for this study reveals that children with intellectual disability are clustered in some county areas more than others. The clustering effect must be taken account of in resource allocation in addition to equity considerations. There are European Union Directives that have recently come into play that allow people to obtain funding for a health care service in another country. This should enable people who cannot obtain a speech and language therapy service in Ireland to cross into Northern Ireland to obtain a service and seek their costs back from the HSE.

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Wexford vs. Wicklow, a tale of two neighbours

While the goal of this programme is for all children to have equal access to a service, this applies only within local health area boundaries. The HSE have looked at service provision for this reform programme of children’s therapy services. Wicklow and Wexford are neighbouring counties yet are at opposite ends of the scale in speech and language therapy provision. It is estimated that Wicklow has 1 speech and language therapist for every 93 children with complex needs. Next door in Wexford there is 1 speech and language therapist for every 388 children with complex needs. It is not envisaged that this programme will see the movement of therapists from Wicklow to Wexford. Therefore, in the absence of additional therapists being recruited in Wexford inequity will continue based upon geographical location.

The concept of geographically based, multidisciplinary teams is poorly understood by the public in its current form. Accustomed to on-site separate facilities for generations, some parents have difficulty understanding the logic of this step towards ‘mainstreaming’ and may perceive it as an administrative ‘trap’ to lock them out of services.

At present, the National Disability Authority is examining the appropriate caseload for therapists (including speech and language therapists). In the absence of this information the closest comparison is from a substantial study carried out in British Columbia, Canada. This study recommended that a speech and language therapist in early intervention service should have a

36 Calculated from figures from the Progressing Disability Services for Children and Young People National Coordinating Group, 2012.
caseload of 30-40 children and a speech and language therapist working in a school age team should have a caseload of 50-65 children\textsuperscript{37}. These recommended caseloads are significantly lower than the best resourced local health area, Wicklow as noted earlier. Based on HSE figures Wicklow has more than 90 children with complex needs for each speech and language therapist.

The Irish Association of Speech and Language Therapists note that there should be 2-3 therapists for every 100 children requiring a service\textsuperscript{38}. As noted earlier Wexford has almost 800 children per 2 speech and language therapists (see appendix 1).

4. PDS: Children with more complex needs

One of the more successful outcomes of parenting is that children learn to speak and develop language at home without the intervention of services or professionals. Some children can learn to speak several languages without much difficulty before they go to school.

An estimated one in ten children in Ireland has a speech and language disorder at the age of nine years old. This is the result of research undertaken by the Growing Up in Ireland team from data gathered in 2008 and using a very large sample of children which reduces the margin of error.\textsuperscript{39} The authors note that speech and language disorders that persist past the age of six years require specialist intervention and that early intervention is important. The study separately tested whether the opinions of mothers of the children, their teachers and independent assessments varied from each other in terms of the gravity of the impairment. They did

\textsuperscript{37}Promoting Manageable Workloads Project: Preferred Practice Guidelines. British Columbia Paediatric Therapists. 2008
\textsuperscript{38}Discussion paper on the allocation of staff to early intervention and school aged disability teams, Progressing Disability Services for Children and Young People, 2013.
not. Ten per cent of children aged two to nine years in 2011 amounted to about 46,000 children.\textsuperscript{40}

Some children have so-called simple or straightforward needs and others have ‘complex’ needs. The distinction between the simple and the complex is not spelt out in policy documents related to therapeutic services. The best indication is that the child has one or more conditions that contribute to a range of functional difficulties. These functional difficulties require the services and support of an interdisciplinary team. The child may require the input of speech and language therapy, occupational therapy, psychology and a dietician to address their needs. The views of professionals or clinicians as to the complexity of need are not to the forefront despite it being the professionals who will ultimately determine the complexity of each case and the ideal amount of resources required to address individual cases.

Children with Down Syndrome have complex needs. That is what syndrome means. It is a collection of signs and conditions which coexist in one person associated with a genetic singularity and which are collectively referred to as a single syndrome. Similarly Autism Spectrum Disorder is a range of coexisting differences in children in relation to the world and relationships, the origins of which are not clear. A syndrome by its nature affects each person differently from the next. It is estimated that about 80\% of children with Down Syndrome have additional health needs associated with the Syndrome. These may be a heart or breathing difficulty, or a metabolic difficulty. The speech and language issues which face children with Down Syndrome and children on the Autism Spectrum are quite different.

The complexity of need has different meanings in different contexts: general public, parents, professionals and service administrators appear to have

\textsuperscript{40} Author’s calculation.
different understandings of its meaning and its impact for receipt of services.

5. PDS: A high level of expertise

With the moratorium on recruitment of therapists into the public sector, many of the current body of speech and language therapists who have remained in the public service will have considerable experience. The recruitment of an additional 80 therapists into the public service as announced in 2013 is spread across several therapeutic disciplines, so it is as yet unclear how many are speech and language therapists. It is not known to parents how many are actually in place across the multidisciplinary teams and to what grades they have been allocated. The 80 (actually 79) include social workers, psychologists, physiotherapists, occupational therapists, and speech and language therapists. It is as yet unknown to the public if these posts have even been advertised. It is also unclear how posts will be allocated and whether counties such as Wexford and Donegal will be staffed to the same level as other counties. Since some teams can be allocated 0.5 or 0.8 of a post, their presence may not be noticeable to parents and their children. While the 80 posts are most welcome it is very clear from HSE figures that many additional posts are required to provide children with the therapy services to realise their fullest potential.

The method by which the additional 80 young graduates/ experienced therapists are to be allocated to local health offices is not clear, although it may be quite simple. For example dividing the numbers of children with a disability by the number of therapists of all disciplines produces a ratio. Ratios can be rank ordered and those with the higher ratios of children to therapists can be singled out easily for therapist allocation. This is not a

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41 Complex needs is also discussed in NCSE (2014) Delivery for Students with Special Education Needs – A better and more equitable way, NCSE, Meath, pp. 32-34.
resource allocation model; it is a simple distribution system using arithmetic. It does not take account of gravity of need or expertise of professional therapists.

The level of expertise in the sub-fields of speech and language therapy is not prominent in policy documents. As speech and language therapy is on the road to becoming a designated profession regulated under statute, this is of some importance. A consultation document from the Speech and Language Therapy Registration Board was published in December 2013. Employers eventually who take students on placement will have to have senior therapists to supervise them and who are part of an educational programme.

The need to reinforce a multidisciplinary culture in assessment of need could also apply to therapeutic treatments. In 2011 an assessment of compliance by assessment officers and assessors with HIQA standards on assessments of need under Part 2 of the Disability Act 2005 found:

Based on the findings the audit team we conclude that while the standards reflect good clinical practice and are well-meaning in intent a comprehensive review is opportune. The team also submit that while there is strong evidence of a person-centred approach the preferred multidisciplinary approach is sub-optimal particularly in relation to Primary Care and can only be achieved if there are well defined and well resourced multidisciplinary teams in place and where there are effective supports in place to support the cohesive collaboration and co-ordination of these teams.\textsuperscript{42}

Supports would involve, amongst others, relieving professional staff of the extremely time consuming self-administration which falls to them, by the

\textsuperscript{42} HSE, Quality and Patient Safety Audit Final Audit Report – Executive Summary, An Assessment of the Compliance by Assessment Officers and Assessors with the HIQA adopted Standards for the Assessment of Need process under the Disability Act 2005, QPSA0182011
employment, or retention of administrative staff. The views of professionals should be highlighted in this regard.

**6. PDS: Best possible use of the resources**

With a ban on recruitment into the public sector, the HSE is obliged to manage ever increasing demand for services with just an incremental increase in resources. This has led, it may be argued, to a proliferation of developments outside of mainstream primary care, the intended location of therapeutic services. Many of these developments are in the private for-profit and not-for-profit arenas.

Hundreds of speech and language therapists within the HSE are providing the best service they can within constraints. In the 2012-2013 period, the HSE was obliged to sanction the spending of €1,350,175 on private assessments of need (not all on SLT). All of the speech and language assessments originated in the Dublin Mid-Leinster Region. 43 While the HSE emphasises that waiting for an assessment of need should not be a barrier to obtaining a therapeutic intervention, on the ground, that is precisely what happens. In response to this, both parents and services seek ‘validation certificates’ or a form of ‘proof’ of disability.

It is difficult to obtain the exact face to face time a speech and language therapist spends with children each week. It is estimated that face to face therapy time could be as low as 20 hours per week. There are many aspects of their job that fall outside of the scope of actual treatment or assessment. Some therapists note it can take more than one full day to type up an assessment report, while it could be dictated in twenty minutes44. This is valuable lost time. Another way to free up therapy time is to give guidance on how long an assessment should take. At present there is significant

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43 Reply of Ms Marion Meany to Deputy Stephen Donnelly, PQ 27574/14 and PQ 27574/14 of July 11 2014.p.2.
variance in assessments. With the support of administrative and clerical staff, therapists could raise the amount of actual treatment time thus reducing waiting lists for treatment and assessments of need.

Private developments are emerging strongly in speech and language therapy. For example the Spectrum Group has four outlets in Ireland. The Speechcentre has seven outlets located in Dublin, Galway, Cork and Kerry. These are in addition to the private speech and language therapists who now have their own association of Speech and Language Therapists in Private Practice.

The private developments are subsequently quasi subsidised by Revenue through the claiming of professional fees as medical expenses.

In the not-for-profit field, the development of alternative clinics, centres and networks such as that associated with Down Syndrome Ireland are witness to the intensity of human, professional and physical resources which are being mobilised to bring professionals and children with disabilities and specific speech and/or language conditions together.

**Can I claim for the cost of Educational Psychologists and or Speech and Language Therapists?**

Yes, but only in respect of a child who is either under the age of 18 years or if over 18 years is in full-time education. Relief is allowable for the cost of an educational psychological assessment.

Note: It is possible for a patient to move from one category to another. Where this happens, relief for each category may be apportioned as appropriate.

February 2014 Office of the Revenue Commissioners

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45 Revenue statement: ‘speech and language therapy carried out by a Speech and Language Therapist for a qualifying person - note Speech and Language Therapist means an individual approved by the Minister for Health
The Case of Speech and Language Therapy – Inclusion Ireland

The intensity of parent’s insistence on specific professional services can be analysed in a variety of ways which are not the subject of this paper. Professional human resources and household savings are leaking out of the provision of speech and language therapy. The use of private assessments of need and therapies is a saving in the long term (in pensions) but not in the short-term in the here and now of this decade.

Conclusions
Speech and language therapy has emerged as a useful proxy for some of the persistent cultural, financial, professional and administrative problematic changes taking place in disability services for children.

- There are extreme differences in services for children depending on which local health area they live in
- The analysis reveals extensive provision which does not articulate itself as a comprehensive service
- The window of opportunity in time to improve the lives of children is being lost in many instances
- Families are ‘hedging their bets’ on waiting lists, using assessment of need under Part 2 of the Disability Act 2005 to counter rigidities in educational provision and availing of private or non-profit providers while awaiting a public service

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• There are tendencies towards fragmentation of provision and privatisation which are interfering with the plan to reconfigure services.

• The reconfiguration of services into geographically based teams is poorly understood in its current form and risks giving rise to mistrust.

• The families of children who access services in the field of intellectual disability or children with difficulties learning, remembering or concentrating are located in county clusters which must be taken into account over and above the need to provide equitable minimum service to all families.

• Privatisation of provision is not the best use of public resources.

• The pathway to statutory regulation of speech and language therapy will require new ways to address the development of the profession.

• Families are spending scarce resources on privately accessing speech and language therapy services.

• A child’s access to speech and language therapy can depend on where they live.
### Appendix 1

**Table A1 Speech and language therapy posts and children with complex needs per HSE area, 2012**

<table>
<thead>
<tr>
<th>Local HSE Area</th>
<th>Number of Speech + L Therapists</th>
<th>Number children – c. Needs</th>
<th>Ratio of Children to SLT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wexford</td>
<td>4</td>
<td>1554</td>
<td>388</td>
</tr>
<tr>
<td>2. Donegal</td>
<td>5.5</td>
<td>1749</td>
<td>318</td>
</tr>
<tr>
<td>3. Louth</td>
<td>5.4</td>
<td>1332</td>
<td>266</td>
</tr>
<tr>
<td>4. Cavan/Monaghan</td>
<td>6</td>
<td>1439</td>
<td>240</td>
</tr>
<tr>
<td>5. Dublin South West</td>
<td>6.83</td>
<td>1529</td>
<td>224</td>
</tr>
<tr>
<td>6. Carlow/Kilkenny</td>
<td>7.37</td>
<td>1566</td>
<td>212</td>
</tr>
<tr>
<td>7. Mid west</td>
<td>18.6</td>
<td>3780</td>
<td>203</td>
</tr>
<tr>
<td>8. South Tipperary</td>
<td>4.6</td>
<td>900</td>
<td>196</td>
</tr>
<tr>
<td>9. Dublin North/North inner city</td>
<td>28.72</td>
<td>5437</td>
<td>189</td>
</tr>
<tr>
<td>10. Kildare/West Wicklow</td>
<td>13.69</td>
<td>2583</td>
<td>189</td>
</tr>
<tr>
<td>11. Dublin South/South east</td>
<td>11.71</td>
<td>2049</td>
<td>175</td>
</tr>
<tr>
<td>12. Waterford</td>
<td>7.04</td>
<td>1156</td>
<td>164</td>
</tr>
<tr>
<td>13. Roscommon</td>
<td>4</td>
<td>643</td>
<td>161</td>
</tr>
<tr>
<td>14. Dublin West</td>
<td>9.93</td>
<td>1561</td>
<td>157</td>
</tr>
<tr>
<td>15. Meath</td>
<td>13.6</td>
<td>2136</td>
<td>157</td>
</tr>
<tr>
<td>16. Cork North</td>
<td>6.03</td>
<td>915</td>
<td>152</td>
</tr>
<tr>
<td>17. Cork North Lee</td>
<td>12.63</td>
<td>1858</td>
<td>147</td>
</tr>
<tr>
<td>18. Dublin South city</td>
<td>6.22</td>
<td>914</td>
<td>147</td>
</tr>
<tr>
<td>19. Laois/Offaly</td>
<td>12.1</td>
<td>1763</td>
<td>146</td>
</tr>
<tr>
<td>20. Mayo</td>
<td>9.3</td>
<td>1301</td>
<td>140</td>
</tr>
<tr>
<td>21. Sligo/Leitrim</td>
<td>7</td>
<td>954</td>
<td>136</td>
</tr>
<tr>
<td>22. Galway</td>
<td>19.8</td>
<td>2448</td>
<td>124</td>
</tr>
<tr>
<td>23. Kerry</td>
<td>13.01</td>
<td>1398</td>
<td>107</td>
</tr>
<tr>
<td>24. Longford/Westmeath</td>
<td>12.8</td>
<td>1346</td>
<td>105</td>
</tr>
<tr>
<td>25. West Cork</td>
<td>5.64</td>
<td>568</td>
<td>101</td>
</tr>
<tr>
<td>26. Cork South Lee</td>
<td>18.49</td>
<td>1796</td>
<td>95</td>
</tr>
<tr>
<td>27. Wicklow</td>
<td>13.44</td>
<td>1253</td>
<td>93</td>
</tr>
</tbody>
</table>

Source: Progressing Disability Services for Children and Young People mapping exercise, 2012.
Notes: the number of children is based upon a prevalence rate for children with ‘complex, ongoing needs’ of 4% of the child population as planned for by the HSE.

The SLT posts relates to whole time equivalent, funded posts. Some posts are unfilled or occupied by persons on leave or occupied by an SLT manager (accounting for up to 17% of posts in total).

Children to SLT ratio calculated by authors and rounded to neared whole figure.

These figures indicate there are 45928 children with complex needs in Ireland. At least 80% of these children will require speech and language therapy which is 36742 children. If the largest caseload recommendation of 65 children is applied to this number the system would require 565 speech and language therapists to meet international recommendations on caseload. Currently there are 283 speech and language therapists in children’s disability services.

There is an average of 162 children with complex needs for each speech and language therapist.
Table A2

**Speech and language therapists by grade and region 2013 measured in whole time equivalent**

<table>
<thead>
<tr>
<th>Grade/Region</th>
<th>Dublin Mid-Leinster</th>
<th>Dublin North East</th>
<th>South</th>
<th>West</th>
<th>National</th>
<th>% National</th>
</tr>
</thead>
<tbody>
<tr>
<td>S &amp; L Therapist</td>
<td>99.1</td>
<td>61.1</td>
<td>66.8</td>
<td>55.8</td>
<td>282.8</td>
<td>34</td>
</tr>
<tr>
<td>Clinical Specialist</td>
<td>4.9</td>
<td>5.7</td>
<td>2.6</td>
<td>1.5</td>
<td>14.7</td>
<td>2</td>
</tr>
<tr>
<td>Therapist Manager</td>
<td>23.4</td>
<td>9.7</td>
<td>14.1</td>
<td>11.2</td>
<td>58.3</td>
<td>7</td>
</tr>
<tr>
<td>Therapist Manager in-charge</td>
<td>6.3</td>
<td>1.0</td>
<td>-</td>
<td>1.0</td>
<td>8.3</td>
<td>1</td>
</tr>
<tr>
<td>Therapist Senior</td>
<td>141.8</td>
<td>112.8</td>
<td>111.5</td>
<td>105.5</td>
<td>471.5</td>
<td>56</td>
</tr>
<tr>
<td>Practice Tutor</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
<td>2.0</td>
<td>2.5</td>
<td>(-)</td>
</tr>
<tr>
<td>Totals</td>
<td>275.9</td>
<td>190.2</td>
<td>195.0</td>
<td>176.9</td>
<td>838.0</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: HSE Staffing by Grade Grouping to December 2013.

Table A3

**Staff by grade and services December 2013**

<table>
<thead>
<tr>
<th>Health Service Executive</th>
<th>Voluntary Hospitals</th>
<th>Voluntary Agencies (Non-Acute)</th>
<th>Total measured in Whole Time Equivalent *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and Language Therapists</td>
<td>604.7</td>
<td>93.2</td>
<td>140.1</td>
</tr>
</tbody>
</table>

Source: HSE Staffing by Grade for Statutory and Non-Statutory Services 2013

* Whole Time Equivalent means that part-time staff hours are added together and are included in the totals.
Chart 1

HSE Measurement of waiting lists in speech and language therapy in 2012
Number of Children under 10 years with Intellectual Disability, 2011

County

Number Intellectual Difficulty

- 40 - 103
- 103 - 237
- 237 - 385
- 385 - 590
- 590 - 780

Children 10 to 14 years with Intellectual Disability as Percentage of total children 10 to 14 years, 2011

Percentage ID
- 0.33 - 0.38
- 0.38 - 0.42
- 0.42 - 0.47
- 0.47 - 0.52
- 0.52 - 0.58

DATA SOURCE: CENSUS 2011, CENTRAL STATISTICS OFFICE.
Total Number of Children 0 to 19 years, 2011

County
Population 0 to 19 years
- 8657 - 17488
- 1748 - 27280
- 27280 - 57530
- 57530 - 82055
- 82055 - 116329

References which have appeared in the text of this report

Abramowska Barbara Ewa (2014) Influence of the movement of parents of persons with intellectual disabilities on the development of science and social life, Warsaw, PSOUU.


CASLPA Steering Committee. (2009) The Development of an Interprofessional Caseload Management Planning Tool in Occupational Therapy, Physiotherapy and Speech Language Pathology in Canada - Background Document. CAOT, CPA.

Centre for Social and Educational Research (2012), Childhood Development Initiative, Dublin Institute of Technology.


CSO (2012 Census 2011, Profile 8 Our Bill of Health, CSO.

Department of Education and Science (2005) Circular - Special Education 02/05.


HSE (No date) Assessing your child’s needs - Disability Act 2005. HSE.


HSE Consolidated Pay Scales, 2013.


HSE (2013) Discussion paper on the allocation of staff to early intervention and school aged disability teams, Progressing Disability Services for Children and Young People.


HSE (2011) Quality and Patient Safety Audit, Final Audit Report – Executive Summary, An Assessment of the Compliance by Assessment Officers and Assessors with the HIQA adopted
Standards for the Assessment of Need process under the Disability Act 2005, QPSA0182011


NCSE (2014) Delivery for Students with Special Education Needs – A better and more equitable way, NCSE, Meath.


