



A Survey of School-Based Speech-Language Pathologists' Attitudes and Perceptions on the Provision of Dysphagia Management in Schools

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Background

•The demand for dysphagia management service provision (i.e., consultation, evaluation, treatment) in schools is increasing as evidenced by an increasing number of students with dysphagia on school-based SLP caseloads

•Previous research (Bailey et al., 2008; O'Donoghue & Dean-Claytor; Owre, 2001; 2006) on this topic include reports of:

- Range of services being provided in schools

- confusion and uncertainty over whether the provision of these services in schools is necessary, relevant, and appropriate, and whether they fall within a school-based SLP's scope of practice

- low levels of SLP confidence to provide dysphagia services and the need for additional training of SLPs

- Negative* relationship (.48) between the amount of formal/continuing education and confidence but positive relationship (.45) when data adjusted to include only education within previous 2 years!

- difficulty establishing the importance of dysphagia management with administrators and colleagues, restrictions of a school setting, liability concerns surrounding student health and safety, logistical and scheduling concerns, lack of administrative support, and a lack of school district procedures, protocols, and guidelines for dysphagia management

Research Questions:

1. What kinds of dysphagia management services are being provided in schools?
2. What are the attitudes, perceptions, and concerns of school-based SLPs regarding provision of dysphagia management in schools?
3. What is the nature of the relations between training and confidence to treat dysphagia in schools?

Method

Design

•This study employed a cross-sectional survey design. Surveys were mailed to 264 SLPs practicing in Vermont.

Participants

•Respondents were 52 masters-level ASHA-certified licensed SLPs (20% response rate, 50 females, 2 males) practicing in the field for a mean of 18 years ($SD = 10.08$). All worked in a school setting (primarily public schools) although some also worked in hospitals, rehabilitation centers, or private practices. Respondents reported between zero and four students currently on their caseload who had IEP goals involving swallowing and/or feeding problems. Respondents evaluated and/or treated 0-30 students ($M = 2.82$, $SD = 5.17$) with dysphagia over the course of their career and 24 (46.2%) reported working as an SLP in a medically-based setting at some point. The majority of never acquired dysphagia CEUs ($n = 37$, 71.2%).

Survey

•The survey gathered relevant demographic information and included 16 statements designed to explore SLP attitudes and perceptions pertaining to several aspects of dysphagia management in schools.

Results

Research Question 1: Types of dysphagia management in schools

Type of Service	Owre (20006)	Present Study
Collaborating with other professionals in the dysphagia management process.	30%	17%
Establishing accommodations and precautions only and ensuring follow-through as a consult.	25%	15%
Evaluation and provision of "hands on" therapy.	42%	15%
Identifying and referring to medical personnel (e.g., medically-based SLP).	35%	15%
Coordinating with medical SLP and school team to evaluate and establish an intervention plan in the school setting.	26%	13%
Obtaining medical information from the child's physician.	37%	13%
Obtaining medical clearance from a physician for dysphagia intervention	25%	8%
Provision of in-service to school staff regarding dysphagia and safe feeding	39%	8%
Managing dysphagia interventions independently	26%	4%
Implementation of established district-wide dysphagia program and procedures	14%	2%

Research Question 2: What are the attitudes, perceptions, concerns of SLPs regarding dysphagia management in schools

Item	M (SD)
H. Restrictions of a school setting (e.g., limited or no access to instrumental assessment tools such as videoendoscopy or videofluoroscopy) pose barriers to the provision of dysphagia intervention in schools.	3.94 (0.93)
F. Despite the low incidence of students with dysphagia on school-based SLP caseloads, additional training in dysphagia is necessary.	3.76 (0.99)
C. It is an SLP's responsibility to complete whatever dysphagia training is necessary to achieve competency in dysphagia intervention in the school setting.	3.69 (1.10)
B. It is within an SLP's scope of practice to provide treatment to children with swallowing and/or feeding problems in the school setting.	3.58 (0.97)
I. Logistical and scheduling concerns pose barriers to the provision of dysphagia intervention in schools.	3.53 (1.16)
A. It is an SLP's responsibility to provide dysphagia intervention to children with swallowing and/or feeding disorders in the school setting.	3.39 (0.86)
K. I am interested in increasing my knowledge in the area of dysphagia intervention.	3.35 (1.15)
D. The provision of dysphagia treatment is educationally relevant.	3.22 (0.88)
J. The risk of the student choking would be grounds to avoid dysphagia intervention in the school setting.	3.00 (1.10)
G. Dysphagia management should be provided by medically-based SLPs only.	2.96 (0.99)
M. My school administrators and colleagues provide a high level of support in my efforts to provide dysphagia intervention to students who have swallowing and/or feeding disorders.	2.94 (0.76)
E. My school administrators and colleagues believe that dysphagia has educational relevance.	2.85 (0.77)
P. I feel confident in my ability to provide dysphagia treatment to children with swallowing and/or feeding disorders.	2.40 (1.20)
L. I am unsure of where or how to seek additional training in dysphagia intervention.	2.24 (0.92)
O. I feel confident in my ability to provide dysphagia evaluation to children with swallowing and/or feeding disorders.	2.12 (1.15)
N. In my school district, dysphagia intervention procedures, protocols, and guidelines are in place to assist SLPs working in the schools.	1.69 (0.87)

Research Question 3: What is the nature of the relationship between training and confidence?

•Positive relation between confidence to treat and number of CEUs (.42), number of practicum hours (.31), and number of students on current caseload requiring dysphagia services (.45). These relation held when data adjusted to include only previous 2 years.

•Respondents who reported working in a medical setting at some point also reported higher degrees of confidence ($M = 2.63$) than those who did not ($M = 1.64$; $p < .01$).

Conclusions

•The present data reaffirm previous findings that:

- SLPs are providing a range of dysphagia service types from aggressive treatment to no treatment at all

- There is disagreement about whether the provision of dysphagia services in within the SLP's scope of practice

- There are general low levels of confidence to provide dysphagia management in schools

- There is general low levels of support to provide dysphagia management in schools

- SLPs who have worked in a medical setting report more confidence in dysphagia management

• Contrary to previous research, the present study found that:

- Every category of service provision was considerably less than those reported elsewhere

- Respondents with dysphagia training (through graduate coursework, graduate practicum, CEUs, or post-graduate experience working in a medically-based setting) reported *more* confidence in their ability to provide dysphagia management services

•Results suggest many SLPs are not adequately prepared to provide dysphagia services and there are obvious implications for the need for additional training and school and district support.

- This should be a priority considering that the number of children with medically-complex problems enrolled in integrated school settings across the country will continue to grow.

•There is disagreement regarding the responsibility of school-based SLPs to provide dysphagia services. This raises questions about the availability of district support that might be provided, such as the development of procedures, protocols, and guidelines to assist SLPs in the dysphagia management process.

Selected References

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