Keighley Sure Start Programme
Local Evaluation

A qualitative study to investigate factors affecting
the effectiveness of the WILSTAAR programme
(Prevention of speech and language difficulties)

August 2004

Dr. Abida Malik
Miss Julia Csikar
Professor Sonia Williams,

Leeds Dental Institute
University of Leeds
Clarendon Road, Leeds LS2 9LU
INDEX

SUMMARY 3
BACKGROUND 5
AIMS 10
METHODOLOGY 11
RESULTS 12
DISCUSSION 22
CONCLUSION 29
RECOMMENDATIONS 31
REFERENCES 33
APPENDICES 34
  APPENDIX 1 35
  Flowchart to show the relationship among the WILSTAAR team 35
  APPENDIX 2 36
  The Role of Health Professionals in the WILSTAAR Programme 36
  APPENDIX 3 (a) 37
  Focus Group Interview Guide for Parents/ Guardians: 37
  APPENDIX 3 (b) 39
  Focus Group Interview Guide for Health Visitors 39
  APPENDIX 3 (c) 40
  Focus Group Interview Guide for Speech Therapist: 40
  APPENDIX 3 (d) 42
  Focus Group Interview Guide for HCSWs (HCSWs): 42
  APPENDIX 4 43
  Details of interview participants 43
  APPENDIX 5 (a) 44
  Information for Parents/ Guardians: 44
  APPENDIX 5 (b) 45
  Invitation and Information for Health Professionals/ HCSWs: 45
  APPENDIX 6 (a) 46
  Consent Form for Parents/ Guardians: 46
  APPENDIX 6 (b) 47
  Consent Form for Health Related Staff: 47
  APPENDIX 7 (a) 47
  Personal Data of Parents/ Guardians: 48
  APPENDIX 7 (b) 50
  Personal Data of Health-Related Staff: 50
  APPENDIX 8: 51
  New Version of WILSTAAR Screen 51
  APPENDIX 9 52
Summary of Sure Start Results - Users’ Perspectives related to Sure Start Activities: 52
SUMMARY

Background: Keighley Sure Start has a diverse resident population. While the majority are white, a substantial minority are of Pakistani origin. The WILSTAAR programme has been introduced into the Sure Start area in order to detect babies at risk of language delay. A screening questionnaire is administered to the parent/carer at the eight month developmental check. Infants are later assessed to check whether intervention is needed. The programme consists of the WILSTAAR Screen, followed as necessary by the REEL Assessment and then the Remediation Programme. The latter extends over four home visits and aims to encourage carers to interact constructively with their child to promote speech and language development. Previous studies have been limited to English-speaking populations. The present study has incorporated a significant proportion of non-English speakers with bilingual support and is the first study to have done so.

Aims: to evaluate whether the Keighley WILSTAAR speech and language programme was achieving its aims and to identify those issues that may inhibit effectiveness of the service.

Methodology: a qualitative approach was adopted using focus groups and one-to-one interviews. These involved identifying the different perceptions of the WILSTAAR programme from the relevant health professionals, a bilingual health care support worker (HCSW) and from white and Asian parents whose infants had previously been participants in the WILSTAAR programme. The tape-recorded meetings were transcribed and subjected to themed analysis as appropriate.

Results: The health visitors were happy to incorporate the WILSTAAR screen into the 8-month visit. In the South Asian community, many of the 8 month developmental checks were undertaken by a specially trained health care support worker (HCSW) who also applied the screening questionnaire in the appropriate language. Both the health visitors and the HCSW felt that the WILSTAAR screening questions were hard to apply. This difficulty had given rise to additional work for the speech and language therapists (SALTs) in double checking with families and may have contributed to the proportion of false positives identified during their initial home-based visit. The layout of the screen had now been modified and was seen as an improvement, although the proportion of false positives had not changed significantly. The health professionals were also aware of potential cultural and linguistic challenges when applying the screen and the REEL assessment and a number of barriers were identified. The parents' knowledge and views about the WILSTAAR Programme varied. The white mothers were able to explain the concepts well, being mostly well motivated and empowered to co-operate with the preventive advice. The Asian mothers were generally less well able to explain its principles or what they were being asked to do. The need for a preventive approach at this age was mostly not well understood by them.

Discussion: These qualitative observations have provided a triangulated approach which can then be interpreted in the context of a recent internal evaluation. This indicated that the mean REEL scores for the white infants improved to a greater extent that those of the South Asian infants,
whether or not those families had a good command of English, over a comparative remediation period - although the latter started their programme, on average, when three months older. It is possible that these findings indicate that there are a higher proportion of Pakistani children with global developmental delay, which responds poorly to the intervention. Alternatively, the whole programme may not be culturally appropriate for this group. Other relevant issues include the level of education and literacy of the main carer, or differences in value systems inherent in the WILSTAAR programme. Communicating the concept of 'at-risk', of prevention, of play is important. In addition, families may feel pressurised due to competing priorities in their lives. In South Asian households, there may just be more people who need to be communicated with, and this is time consuming. The HCSW is very pressed for time, yet more time may be needed to get families to fully understand about WILSTAAR and what they can do to help. As previous WILSTAAR programmes have excluded all bilingual children and children with developmental delay, it is impossible to draw any further comparisons at this stage.

**Conclusions:** The Keighley WILSTAAR speech and language programme would appear to be achieving its aims in the white community. Further work needs to be undertaken in order to determine the issues underlying the relative lack of success in the South Asian population. A number of factors have been identified that may inhibit the effectiveness of the service in general and recommendations have been made.
BACKGROUND

Keighley Sure Start is a second wave programme that received approval in October 2000. The catchment comprises the Braithwaite, Guardhouse and Highfield areas. The locality suffers from crime, social exclusion, poverty, unemployment and ill health. The hilly topography makes mobility difficult without transport in some areas.

There is a diverse resident population. While the majority (78%) are white, approximately 20% are of Pakistani origin, plus a small proportion of other South Asian and African Caribbean communities. The Highfield area consists mainly of privately owned Victorian terraced houses with backyards, where the minority ethnic communities largely reside. In contrast, the Braithwaite/Guardhouse area consists of council owned houses, bungalows and flats, together with a smaller number of owner occupied properties and has a predominantly white population.

The Keighley Sure Start Delivery Plan identifies the longer term aim 'to work with parents and children to promote the physical intellectual and social development of pre-school children, particularly those that are disadvantaged, to ensure that they are ready to thrive when they get to school'. This includes reconfiguring facilities in imaginative and challenging ways in order to provide services appropriately responsive to their needs. A diverse multicultural population also requires activities to be culturally and linguistically appropriate so that specific needs are met within the over-arching objective to improve social and emotional development, health, the ability to learn and to strengthen families and communities.

Speech and language delay is a common developmental difficulty. Research indicates that children from disadvantaged backgrounds frequently have poor spoken language skills and that the promotion of literacy is enhanced by the development of spoken language. A health needs assessment conducted in 2000 reported that 14% of young children resident in Keighley Sure Start were identified with speech and language delay by health visitors. The PSA target 'Improving children's ability to learn' underlines the importance of reducing the proportion of young children with speech and language problems requiring specialist intervention by the age of four.

Language performance tests carried out at the age of 3 years are predictive of education attainment. There is also a high correlation between delayed language development and learning disability and with behavioural/emotional difficulties. Therefore, it is probable that early detection and the instigation of a remediation programme would help to prevent secondary emotional disorders. WILSTAAR (Ward Infant Language Screening Test Assessment Acceleration Remediation) is an
example of such a programme. It was developed by Sally Ward in Manchester, in response to the growing number of children with language difficulties being referred for treatment, the increasing severity of their problems and a particularly large number of associated listening problems. The original WILSTAAR programme was confined to an English-speaking population. The exact wording and protocol for the screen is strictly prescribed by the inventors. The questionnaire must be administered before the hearing test, so that the latter does not influence the carer's response.

The WILSTAAR programme aims to (a) detect babies at risk of language delay via a screening questionnaire administered to the parent/carer during the eight month developmental check, (b) assess the babies that have been detected to check if intervention is needed and (c) to intervene where this is necessary. It has been shown that the use of the WILSTAAR screen coupled with an early intervention (before 12 months of age) can significantly improve children’s speech capacities by the age of 3 to a level similar to their normal peers. This benefit can still be detected at 7 years of age. The WILSTAAR programme is composed of three parts: (a) the WILSTAAR Screen (b) the REEL Assessment and (c) the Remediation Programme.

The WILSTAAR screen consists of seven questions and has receptive and expressive components (Appendix 1). The former detects any abnormality with the auditory behaviour, which could have contributed to language delay whereas the latter component relates to the language delay, which is independent of the listening difficulties. The WILSTAAR Remediation Programme employs the use of a natural interactive approach in the child’s home by empowering parents to support the development of child’s selective attention, listening, speech and language.

In Keighley Sure Start, a WILSTAAR programme has been instigated. However, here it aims to address the speech and language developmental needs in both white and minority ethnic population groups, some of whom are non-English speakers. The initiative was started in January 2001 and initially confined to the Braithwaite/Guardhouse area before being rolled out to include Highfield in the first quarter of 2002. Early identification of speech and language problems is achieved by a coordinated approach via a complex team of service providers, interacting with appropriate service users. During the period of this local evaluation, the Keighley WILSTAAR team consisted of mainstream health visitors, one Health Care Support Worker capable of communicating in Urdu, Punjabi and English, three speech and language therapists and if required, a bilingual Sure Start worker.

The health visitors are normally responsible for administering the WILSTAAR Screen during the eight months child health assessment. The Screen was an additional intervention provided for those infants resident in the Sure Start programme area and consists of a series of questions to the parent
about the child's behaviour. The completed Screening forms are then forwarded to the Speech and Language Therapists to evaluate the need for an intervention. If the results indicate that this is necessary, arrangements are put in hand for a home based visit. The speech therapists conduct the initial assessment as a pair, usually in the domestic setting, where they then plan the programme sequence, support the families to implement it and subsequently maintain records for evaluation. Appendix 2 shows the relationship between the personnel engaged on WILSTAAR project. The Health Care Support Worker has a key role in facilitating the programme for the non English-speaking families.

The assessment carried out by the two Speech & Language Therapists (SALTs) covers a linguistic development test – REEL (Receptive-Emergent Expressive Language) Scale. This test is performed at the first and the final review in order to determine the extent of any improvement. General development is scored using a checklist and subsequently an analysis is undertaken to determine the nature and the sequence of recommended remediation items (e.g. audio tapes to assist parents to sing along action-rhymes and the use of recycled household items to serve as toys). During the Remediation Programme each child is given a series of four programmes and revisited at monthly intervals to help to bring the child's development more in line with normal values. Advice can be offered in written format or, where there is a literacy issue, with individualised cassettes recorded during each visit. The REEL scale is administered again during the fourth visit in order to assess any beneficial effect of the remediation.

The challenge of conducting the WILSTAAR Screen in Keighley Sure Start includes addressing the cultural and linguistic components. These were issues that did not feature in the original programme. Aspects of communication across different elements of the team, as well as with the families and/or the use of the specific measuring tools may compromise the effectiveness of the measure, especially when accompanied by linguistic and cultural differences.

An internal evaluation of the Keighley programme has indicated that of 53 babies screened between October 2000 to June 2002 in the Guardhouse area, 31 (58%) passed the WILSTAAR screen compared with the 80% in the original study carried out in Preston and Manchester. This observation raises the question as to whether the Keighley Sure Start infant population are in relatively greater need of remediation or whether the WILSTAAR questionnaire provides valid information in this multicultural population group. The latter appears to be at least part of the picture, since later confirmation of these results by speech therapists showed that a number of babies who originally failed the screen and identified as at risk of developing communication delay were false positives, having been wrongly classified.
The infant's parents/carers are key to understanding what may be happening here. The assessment by health visitors and speech therapists heavily relies on parent’s/carer’s reporting of the child’s skills. In addition, the level of co-operation by the parent/carer to the programme can also influence the outcome of the study. In Keighley Sure Start, the problem may be accentuated by additional language and cultural factors that could contribute to gaps in communication, including the possibility of a proportion of incorrectly identified cases.

The original WILSTAAR study was conducted among the caregivers of all infants incidentally attending for a routine screening test for hearing over one calendar year in Manchester NHS Trust. A clear and measurable benefit was demonstrated with this intervention in this setting. The mean age at screening was 9.3 months with a range of 7-23 months. Overall, 1070 participants were screened, while a further 50 had declined or were non-English speaking. There was no evidence as to the social background of the sample. It is against this background that the question arises as to the appropriateness of this form of intervention in a Sure Start population in a multicultural setting as in Keighley. The stated objectives of the Keighley WILSTAAR Programme are:

- To train health visitors to screen babies during the 8 month check, in order to detect those at risk of communication delay
- To provide cost-effective early intervention advice to parents of babies who are identified as being at risk of communication delay
- To facilitate early intervention of relevant children developing communication delay (which will also prevent the social, educational and emotional delay)
- To facilitate early intervention so that a reduced number of children need to be referred to speech and language therapy at a later stage.
WILSTAAR: the process in summary:
(Keighley WILSTAAR programme in italics: also see Appendix 2)

- Speech and language therapists meet with the health visitors (for training). *HSCWs also trained*

- Health visitors and *HSCWs* administer the screen at routine 8-months hearing test. Send completed questionnaires to speech and language therapists.

- Original programme excluded non-English speakers. *The Keighley programme is inclusive.*

- Speech and language therapists score questionnaires and send letters of introduction to carers of infants 'failing'.

- Speech and language therapists assess 'fails' at home. Give initial programme. *They may be accompanied by an interpreter, as necessary. The visit may be followed up by the use of instruction audiotapes in the relevant language.*

- On return to clinic, compile second and third programme.

- Two weeks later, revisit. Give second programme if appropriate.

- Four weeks later, revisit. Give third programme if appropriate.

- Four weeks later- revisit. If ready, reassess on REEL. If appropriate, discharge. Discuss and leave summary programme.
AIMS

The aim of this study was to determine whether and to what extent the Keighley WILSTAAR speech and language programme is achieving its aims in detecting, assessing and intervening where there is evidence of language delay, together with identifying those issues that may inhibit the effectiveness of the service.

The study incorporated the following objectives:

✓ To identify those factors that influence the efficiency of the WILSTAAR screening and home visiting service in relation to the characteristics of parents/carers.
✓ To explore the knowledge base and identify any gaps in the training of the health care support workers (HCSW) regarding the WILSTAAR programme including in relation to the linguistic and cultural needs of the users.
✓ To explore perceptions associated with the significance and usefulness of the WILSTAAR screen used by health visitors and speech therapists.
✓ To identify barriers to access to Sure Start services generally, by the parents/carers.

This investigation aims to enquire into the causative factors and make appropriate recommendations to inform changes in service planning with the view to gaining:

• A better understanding/insight into issues surrounding speech and language problems as perceived by the users, and
• Determining how to increase efficiency, including a reduction of the number of false positives
METHODOLOGY

Exploratory work was initially undertaken by a multilingual Research Fellow (AM). She accompanied health visitors and speech and language therapists in order to observe various factors that could affect the study outcome. Information derived from this activity helped in the formulation of interview guides that would require further consideration when constructing a schedule for the subsequent interviews.

Initial work indicated the need to consider various perspectives across a range of stakeholders, namely parents/carers, health visitors, speech therapists and health care support workers. A qualitative approach was adopted in order to assess the various perspectives in depth. Permission to undertake the study was obtained from the Bradford Local Research Ethics Committee.

A detailed schedule used for facilitation of various focus groups is shown in Appendix 3. Various aspects of the service were explored by interviewing participants as follows:

1. Asian parents - one-to-one interviews (one father and 3 mothers)
2. White parents – focus group (4 Single mothers)
3. Health visitors – focus group with 8 participants – English speaking experience only
4. Speech Therapists (1 Bengali and 4 English)
5. Health Care Support Worker - One-to-one interview
6. Health Visitor working with Asian community - One-to-one interview

Further details of the participant groups, including selection criteria and interview criteria are given in Appendix 4.

Participants were given information (Appendix 5) about the research and their consent (Appendix 6) was sought prior to their participation in the focus groups or individual interviews. The cooperation of the respondents was also requested in order to gather some further data as specified in Appendix 7. Where parents were not available to leave the house to attend focus groups, domiciliary visits ensured access to them on a one-to-one basis.

Group and one-to-one discussions were audio recorded. Conversations were transcribed in order to organize findings thematically. Common responses to the questions were extracted from the data as well as broader themes at a more conceptual level (share ideas and meanings). Grounded theory was used to extract respondents’ own understandings and explanation of the difficulties with their infants’ speech and language. The ultimate aim was to develop agreed models of good practice and inform the service planning process.
RESULTS

Introduction:
The views of all participants were successfully elicited regarding their various perspectives of WILSTAAR programme provision. The mothers from Guardhouse were able to meet in a community centre in order to form a focus group, whereas the Highfield parents were all interviewed individually in their respective homes, using English, Urdu or Punjabi as appropriate.

The findings have revealed a wealth of data. These have been collated and presented under various themes. This results section follows the WILSTAAR programme chronologically, considering the various components in relation to perspectives of the different groups of respondents.

The WILSTAAR Screening Visit:

Several health visitors are involved with the 8-month screening of infants resident in Keighley Sure Start, but only one is directly involved in working within the Asian community. While very conscious of the cultural and linguistic needs of this community, this lone health visitor lacks the advanced language skills and can therefore only work with English-speaking families or with the help of an interpreter. A Health Care Social Worker (HCSW) resident in the Highfield area of Keighley has been trained to perform many of the routine 8-month developmental assessments normally undertaken by health visitors, among non-English speaking families. However, if a family represents a particular challenge, for instance in relation to special care needs or child protection issues, then the HCSW would be accompanied by a health visitor.

Most of the 8 month evaluations are performed in the domestic setting in both the Highfield and Guardhouse areas. This pragmatic approach was thought to be best, since 'people do not like to come out of their homes'. 'Bringing them to the clinic is so difficult!' From the health professional's point of view, there was also felt to be some benefit in assessing the child as part of the family in the family setting, although it was not considered to be 'cost-effective'.

Alongside their other developmental assessments at 8 months, health visitors conduct the WILSTAAR screen. Health visitors felt that, as long as they had completed the appropriate training, the WILSTAAR screen only needed about 10 minutes concentrated time. The questionnaire represents 'a little extra work', but was not felt to be a great inconvenience. Overall, health visitors were more concerned about the general workforce shortage for the non-English speaking sector of the community, but overall, given the special WILSTAAR induction training, the health visitors thought that it was 'a brilliant service'.
The HCSW integrates the WILSTAAR screen for the Highfield infants with other activities due at the 8-month stage. Many of these visits are conducted on her own.

‘The first thing … we do … is the WILSTAAR screen and then … hearing test. Then we discuss child’s diet, feeder cups, and dental health. Safety … also takes us into… issues covered by Sure Start such as safety equipment. We also discuss anaemia and what could cause that. We enquire about the child’s weaning practices and whether the mothers have started them on solid food or not. There are many other things that we discuss with them.’ (HCSW)

The 8-month developmental check lasts about 20-30 minutes, although some families may need more time than this. The HCSW explained that, in relation to the WILSTAAR screen, she had ‘one full days training, on how to ask and the words to use.’ She did not feel the need for further training, but she did consider that she was ‘fully stretched’ and that the work schedule was ‘very hard on her’.

**The conduct of the screen**

It was clear that the health visitors and HSCW were concerned about the appropriateness of the WILSTAAR screening questionnaire. There was a strong feeling that the form should be simplified. ‘Some questions are uncomfortable, the way they are worded’. The health visitors for the white English-speaking communities explained that this had all been discussed during their training. You ‘cannot change the words’, even though the questions are ‘complicated’, the language is ‘complicated’; there are ‘double negatives’, so you feel ‘helpless’! The health visitor working with the Asian community felt that the contexts of the questions in English were 'White middle-class educated stuff'. When the text had to be translated, further difficulties might arise with the meaning being lost in translation. According to the views of the health visitor working in the Asian community 'The WILSTAAR questionnaire is so difficult', 'there are problems with interpreters, getting the right dialect'. Nevertheless, 'they are picking up at-risk children, but it's very difficult'. She felt that a lot is lost in translation and that because of these issues, it was essential 'to get the right person for the right job'.

‘With translation, human contact is much slower (under any circumstances). But when you have something like WILSTAAR to deliver, which is much more structured, you have to try to deliver it in a special way, it is so difficult. When I read the WILSTAAR questions myself I find it difficult. There the poor interpreter is being asked to interpret that back into another language so you are losing a lot, I could not put a figure on it, and I could not put a word on it. You MUST just by the...
nature of it be losing something. So if I was with someone who understood exactly what I was saying you could hopefully get 100% results. If you are going through in a language, which does not fulfil the words on the paper, you must be losing something and that’s my biggest concern. This is educated stuff to understand at first reading and here we are talking about women who have come from Pakistan who probably have no education. So I worry about it.  (Health visitor)

More recently, the WILSTAAR screen has been adapted in terms of its layout. The format has now been extended onto an A4 sheet, which made it easier to complete (Appendix 8). The potential range of answers was extended from 'yes' and 'no' to also include 'DK' (don’t know). The health visitors and HCSW felt that this was a distinct improvement, although the language of the questions remained the same. If parents were puzzled by the questions, health visitors have been trained by the speech therapists to use standard English examples in order to clarify the meanings.

The speech and language therapists receive the WILSTAAR screening forms after they had been completed by the health visitors or the HCSW. They also noted that when in the original format, some of the questions were not answered or had a question mark. This then meant that the therapists must telephone the respective family to clarify the situation. Since the questionnaire has been simplified, it is reportedly much easier to administer. There is normally no need for further clarification with families, as before.

The Speech and Language therapists noted that parents were rarely aware of a delay in speech and language potential at 8 months. The health visitors appreciated getting feedback about the results of the WILSTAAR screen that they had forwarded to them for scoring, as vindication of their efforts.

The context of the Screening environment

In any home visiting situation, there are possibilities for distraction. The professional groups mentioned quite a few of them. The South Asian HCSW felt that her families are very inviting and welcoming. However, the television can be a distraction - which 'you can ask to have turned off.' There may be 'lots of children', in which case; it can be advisable to ask the mother to move into another room in order to concentrate on the purpose of the visit. Other family members may wish to contribute - grandmother, granddad, aunties, sisters-in-law - and 'it is good that they are listening too'. She contended that, over the course of the visit, older members of the family may come to agree with her - 'BUT what actually happens when I leave is left to the imagination. Only they know whether they actually implement the message that I have tried so hard to press in.' This HCSW also felt that the health visitor with whom she worked was also very aware of that community's needs.
The health visitors working in Guardhouse also explained that there could be distractions, including the television, during their visit. It would very much depend on the particular family being visited.

**The first visit by the speech and language therapists**

Once the speech and language therapists have evaluated the WISTAAR screen, a letter is sent out to those families together with an appointment for a home-based visit, where it is judged that the infant could be at-risk of language delay and might benefit from the remediation programme. In the Highfield area, a bilingual letter in Urdu/English is used. Nearer the time of the appointment the family will receive a follow-up call to remind them about the impending visit. Contact is then made to confirm the appointment by telephone nearer the time. Some families enrolled into WILSTAAR are not registered with Sure Start programme. Membership of Sure Start is not obligatory in order to benefit from the WILSTAAR service, but it is encouraged. Most families make themselves available for this visit.

Health visitors supply additional information to the speech therapists about the child or family to be visited: e.g. special needs or language used. As with the health visitors, speech therapists felt that people are more relaxed at home and more willing to take advice. Home visits also gave them greater insight into how the children are being brought up, for instance in terms of the parent/child interaction in a more relaxed setting or how many toys or books there were in the house.

One of the white mothers, who had experience of speech and language problems in her childhood declared that this first contact from the speech and language therapists made her anxious. ‘I felt that the health visitor had taken action behind my back. It brought back my own memories.’ She explained that there was a need to explain more and to reassure parents. She also wanted as much feedback as possible as the programme progressed.

In the white, English-speaking Guardhouse area, the speech and language therapists visit in pairs. In the Highfield area, three people may visit, the two speech and language therapists and an interpreter. Since there are two speech and language therapists present, one will be playing with the child and independently appraising his/her responses so that a judgement can then be made as to whether these observations and the corresponding parental responses are congruous.

The speech and language therapists were sensitive to problems that might arise when using family members for interpreting, or when untrained bilingual staff are used. They preferred to use the Sure Start HCSWs, who are trained, have background knowledge and constructive personalities.
'Sometimes even if we take someone as interpreter, we need somebody with knowledge of the speech and language therapy questions we are asking, because that certainly didn’t feedback. One of my colleagues who was on a joint visit actually said afterwards that the person interpreting, who was not from our department, did not fully report back what the Mum had said to P*P and myself, so we didn’t pick up all the information. We would never have known that if it wasn’t for the fact we had another bilingual member of staff who was in the room who noticed that not everything had got back. (Speech and language therapist)

The speech and language therapists were also aware of potential difficulties with parental responses to the questionnaire. This could be the result of misunderstanding or of lack of understanding or of differing perceptions of the truth. It was also suggested that several South Asian families are suspicious of those interpreters who are local, fearing that confidentiality might be breached - so they give a 'desired' response.

‘….where I work it is very insular, it is very old fashioned, it is very suspicious and a lot of the (interpreting) workers are living within that area. I don’t get as much if I take that person with me and the management don’t want to hear that because it is not politically correct. I worked with an interpreter who came from Bradford and the mothers opened up like anything because they did not know her, and she did not know their family…’ (Health visitor)

Of one of the HCSWs ‘….They trust her. She does not break their confidentiality. Interpreters we use at ad hoc basis are not so good… (Health visitor)

According to the speech therapists, an additional challenge concerns the extent to which families are willing or able to understand the issues they are explaining. Even if they do understand, are they willing to follow the advice? Often parents may say 'yes', but it does not always mean that the advice will be taken. Normally, the speech and language therapists go back to the home every month and reassess again at the end. If at the second visit, the parent has not been following the programme, they are given 'another chance'.

**Understanding the rationale for the visits and gaining co-operation**

The white mothers in the focus group were all single parents. They had a very clear view about the WILSTAAR programme. Overall, awareness of speech and language therapy was widespread. They understood that their infant was at-risk, that there was no problem at that age, but that the programme stopped difficulties developing later at 3-4 years of age. One mother felt that the need for speech therapy later 'labels a child'. She had such a problem herself as a child. The
WILSTAAR programme was appreciated because it helped get rid of that stigma, by intervening early.

The visits from the speech and language therapists were much appreciated by several Guardhouse mothers. They saw it as an opportunity for their child to have quality time from someone else, and the children loved getting the undivided attention. However, one mother felt that too much was being expected of her child (at 8 months).

’G… (my son) used to enjoy the time when they came out – probably more so with me being a single parent. I found it very hard to organise myself, … for G… it was like quality time… from somebody else. So he actually did enjoy taking part in the program. Every time they came out with a different activity he seemed fine with them’. (A white parent)

’I think she enjoys the toys that they’ve brought… they would have cost me a fortune if I’d had to go out and buy something like that’ (A white parent)

’I think the problem with her (young daughter) is – she’s so quiet – she didn’t really want to mix with others – and so when she (the speech therapist) came around …. She got the idea after a couple of weeks so, yes, she enjoyed it. (A white parent)

Among the Asian parents, there was some ambiguity in understanding about the WILSTAAR programme. One mother objected to being contacted by the health care support assistants and preferred to deal with the speech therapists directly. Some were confused about who it was who was visiting them, calling the speech therapists ‘doctors’ and ‘nurses’. One mother felt that she did not get enough feedback regarding her child's progress over the duration of the programme.

Other communication issues

The speech therapists thought that the WILSTAAR visits could raise general awareness about speech therapy more widely. This type of multi-agency working could also improve relationships between the health visitors and themselves.

Among the South Asian community in particular, the speech therapist felt there was a clear need to motivate parents to co-operate more. Building up trust was an important aspect. As one health visitor explained, 'WILSTAAR is something you ask parents to understand.’ There are only three workers involved to meet local language needs. They lack the time to explain fully. In addition, because they are all local, there are potential problems with suspicion. She reiterated that it takes
time and trust, and that it is a false economy if there is not the 'manpower' or money to deliver the programme properly.

'I think you can observe what is going on in a communication with a parent and with an interpreter. You can see whether people are taking on board the information and whether they are understanding what you are getting at. So maybe you can predict the sort of reactions that they are going to have on suggesting that a parent follows the advice'. (Speech & language therapist)

'....It also gives the parent a new sense of chatting to their children or talking to their children because sometimes it is difficult as a parent to understand why you need to talk so freely to your child, rather than just help them to eat and sleep. It is about helping the parents to educate and helping them to get on with the speech and enjoy themselves…’ (Health visitor)

The speech therapists also acknowledged that there could be 'cultural issues' and difficulties with parents, both in English and in South Asian languages. One key issue is whether what they are being asked to do is different from their expectations. They thought that a relatively high proportion of people do not really understand the implications.

Within the cross-cultural context, compliance and trust are very significant issues, as are the carer's skills and competence with the child. For instance, there must be an acceptance that a mother 'plays' with her child, to make the remedial interaction more successful. But of course, any recommendations can be applied in the preferred language of that family, it does not have to be in English.

'....you are looking at trying to educate parents who probably have no formalised education, about speech, about play, about talking to children, about laughing with them, about books. This is what I find in my area, when you are talking to an educated family not just white but anyone who is educated; when you mention speech they know exactly what you are talking about. You go into some of our families (referring to Highfield area’s Asian families) you are back here (pointing with her hand to a lower level) trying to get them to here (pointing to a higher level). (Health visitor)

'....they are looking at you thinking this is all Western culture, what are they talking about? So you are far behind even before you have caught up. It is not disrespectful but it is a fact that some of the mothers are educated but they come from a completely different way of life. And here I am, a white middle class woman trying to put this stuff onto other people and this is where we get it wrong ...' (Health visitor)
Regarding failed appointments, the speech and language therapists acknowledged that a family that they had booked to visit is sometimes out when they call. This is not just an issue in the South Asian communities but can arise with White families too.

**Perceiving the benefits of the WILSTAAR programme**

Each group was asked their views about the value of the programme. The speech and language therapists emphasised its preventive nature, 'get them early', 'preventing problems starting', and reducing the likelihood of referrals at a later age. They saw themselves as focusing on the infant at a time when parents do not realise that the child is at risk (not identified as having problems). Indeed very few parents request a referral at this age. So speech and language therapists are careful how they word the situation for parents, to avoid anxiety. In the longer term, they claimed that 'There are real improvements'. 'We are checking how many come back into the system and are referred.'

In terms of supporting the South Asian community, the professional staff were all enthusiastic about the programme, perceiving the preventive approach with the emphasis on early detection and intervention as its great strength. It was also seen as a means of identifying children with special needs, particularly among the Pakistani community, where they were more likely to occur.

Many of the parents identified two and a half years of age as the time when they might expect the child to start speaking and therefore they would not have concerns before this. On behalf of the white community, the WILSTAAR programme was seen as identifying delays, so that an early intervention could make the tasks lighter and lead to more positive outcomes. It was perceived as helping children to achieve their full potential.

'...My children never had any behaviour problems but communication is better... It improved my relationship with her. She had the telly off. There was a set time. I think it was for about five or ten minutes, a set time for you and your child .... Yeah, and you got your background – she could do Hickory Dickory Dock or whatever.... pick a nursery rhyme and say it and what’s the time, and make the clock go tick-tock tick-tock ...., I remember it well'. (A white parent)

'You are more aware of your speech. It got better. Yes, even though it was my third, you were more aware.... oh right, this is how I get him to turn this off, this is how I get him to do that. And how you can pronounce the words in general. (A white parent)

Compared with the Asian carers, the white parents were far more vociferous about potential benefits. They knew that the programme was designed to pick up problems early and to help
prevent difficulties developing as children get older. 'My little girl learned a lot .... and the older children benefited because they could understand and play with her more easily.' 'Feeding and speech problems improved at the same time.' However, others identified some other events as having an impact 'NN started talking on going to the playgroup.'

Among the Asian families, the terms 'speech therapy' and speech therapist' were not universally recognised. The speech therapists were often referred to as 'nurses' or in one case, as 'doctors'.

'It is the doctors who know best. I think that talking to doctors will help'.
'I am not sure who the nurse was?'

One English-speaking South Asian mother was quite positive about the WILSTAAR experience and understood the concepts much better. The immediate benefits were also appreciated.

'... It is designed to help children with speech problems. Speech therapists come.... First of all they test the child’s speech and if needed they provide the therapy. After some time they test it again to see whether it has made any difference. They finished with my son about 6- 7 months ago and helped him for over a year...'

'... My older children can understand him better and also they like playing with his toys! ...'

In contrast, some of the other Asian mothers were more sceptical about the benefit of the intervention.

'... I can’t honestly tell you whether it was the nurses’ intervention or mixing with his cousins in Pakistan which did the trick.....I was never worried about his speech because it runs in the family and they all eventually pick up. My son started to talk at the age of 2 ½ years and that is OK. (An Asian parent)

'...the nurses said it is meant to boost children’s language before they start school. But our children always start to talk before they join the school so what is the problem?’ (An Asian parent)

**Summary:**
Overall, several key themes have emerged. These are summarised in Table 1. Professional staff were generally supportive of the programme and felt that it could have important benefits. The screening questionnaire was perceived by health visitors as quite difficult to apply. Recent changes in layout had made the form more user friendly, but according to the protocol for the WILSTAAR
screen, the original wording of the questions remained. There were also concerns about achieving clarity in translation. Variations were observed between South Asian and white mothers in relation to their understanding of the rationale for the intervention or of its benefits.

Table 1: Summary of key themes emerging from the qualitative evaluations

<table>
<thead>
<tr>
<th></th>
<th><strong>White carers</strong></th>
<th><strong>Pakistani carers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family setting</strong></td>
<td>White single mothers; main carer</td>
<td>Extended families, other children; possibly many carers</td>
</tr>
<tr>
<td><strong>Interview setting</strong></td>
<td>Focus group</td>
<td>Individual interviews</td>
</tr>
<tr>
<td><strong>WILSTAAR screening visit</strong></td>
<td>Conducted by health visitors in English</td>
<td>Normally conducted in own language or in English by trained HCSW. Some at-risk families visited by health visitor + HCSW</td>
</tr>
<tr>
<td><strong>WILSTAAR questionnaire</strong></td>
<td>In English, with examples</td>
<td>In English or own language, with examples</td>
</tr>
<tr>
<td>(seen as complex)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SALTs visits</strong></td>
<td>2 SALTS attend REEL score in English</td>
<td>SALTS + 1 HCSW/ interpreter attend. REEL score in own language as required</td>
</tr>
<tr>
<td><strong>Carer’s understanding of WILSTAAR</strong></td>
<td>Explained concepts well (within focus group)</td>
<td>Not so well understood, except in one case</td>
</tr>
<tr>
<td><strong>Carer’s description of active involvement</strong></td>
<td>Well documented, sense of empowerment &amp; motivation</td>
<td>Not evident that they were asked to do things: evidence of ‘dependency’</td>
</tr>
<tr>
<td><strong>Recognition of need for preventive approach</strong></td>
<td>Mostly well understood and benefits explained</td>
<td>Mostly not well understood</td>
</tr>
<tr>
<td><strong>WILSTAAR service appreciation</strong></td>
<td>Service valued but most requested more periodic feedback on the progress of their child</td>
<td>Service mostly valued: some would like more feedback on the progress of their child</td>
</tr>
</tbody>
</table>

The interview guides for each of the participant groups also enquired into the views and experiences of the Keighley Sure Start Programme. The results of these discussions are summarised in Appendix 9.
DISCUSSION

This study involved a qualitative methodology using small numbers of participants in order to gain insights into the conduct of the WILSTAAR programme. In addition to the health visitors, speech and language therapists and health care support workers, the original sample was designed to involve focus groups involving previous users of the WILSTAAR programme, from the white and Asian resident communities.

A number of challenges affected the progress of the research. While it was feasible to arrange a focus group meeting for the white mothers, this proved to impossible for the Asian carers, who were therefore interviewed on a one-to-one basis in their own homes. As arranging for four one-to-one interviews added to the time scale beyond that previously allowed for, the month of Ramadan intervened in the progress of the research, since no one was then available to be interviewed. These individual interviews had to be postponed until after Eid ul Fitr (the festival at the end of the month of Ramadan).

The Guardhouse carers were all white single mothers. The four Pakistani parents from Highfield included one father, while the child of one of the mothers had special care needs. The focus group format allowed for shared discussion of topics and the interaction of common themes. The one-to-one interviewing provided no such opportunity for sharing, with the result that such mutual interactions did not occur. However, in each case, the interviewing environment provided additional sources of variation. Mothers brought toddlers and children to the focus group, where they were partitioned off in a crèche. Placed in unfamiliar surroundings, some children became anxious. This source of distraction influenced the quality of interaction between members of the group, thus making it more challenging to recreate the group scenario and capture the impromptu responses. In the domiciliary setting, interruptions included short pauses caused by children, visitors or telephone calls and satisfying questions from other female members of the family. In a one-to-one setting, these intrusions were relatively easy to accommodate in relation to the communication flow. The extent to which the different methodologies and interruptions will have prejudiced the discourse or the development of the themes is impossible to gauge, but it is clearly likely to have had some influence. Further qualitative work in similar community settings will need to look for imaginative ways of mitigating against such effects. Since there was no separate note-taker, the transcription had to be performed by the researcher in charge of data collection in order to minimise errors in this aspect of the work.
A further source of bias is the use of a convenience sample of previous users. However, the background characteristics of participants was sufficiently wide to include variation in terms of single and married parents, families with one or more children, children with special care needs, between English and non-English-speaking Pakistanis and included a father as well. Therefore it can be concluded that a wide range of participants were represented, an outcome of value in its own right.

The original version of the WILSTAAR programme was confined to English speaking populations. Its applicability to non-English-speaking populations has remained to be investigated, in terms of either its linguistic or cultural impact. This is the first study to address this issue.

The compliance of health professionals is a key element to successful screening. As in an earlier Leeds study\textsuperscript{15}, which was confined to English-speakers, health visitors in Keighley Sure Start area reported that their involvement in the WILSTAAR screen did not significantly increase their workload. In Highfield a HCSW is being used for the delivery of the screen and is therefore important that anyone employed in that capacity thoroughly understands the WILSTAAR instrument and is quite comfortable with the cultural and linguistic needs of the parents. The HCSW would also need adequate time allowance to administer the screen properly and hence avoid any error at this crucial diagnostic stage. However, the HCSW did feel that her capacity to undertake this work in the local Pakistani community was being stretched.

As in the Leeds study, health visitors in Keighley also raised their concerns about the content of the WILSTAAR screening questionnaire, in particular that questions were more difficult for some parents to answer and often required further explanation, by giving examples. The results of the present study suggest that high level language and complex sentence construction were responsible for these problems, even for English speakers and that the original WILSTAAR protocol did not permit rephrasing\textsuperscript{13}. Nevertheless, they felt that the change in the layout of the screening form had helped to ease the problem.

Internal evaluation using the original screening format in the Guardhouse area in Keighley (March 2001-October 2003) revealed that 20% (7/35) were false positives. Since the questionnaire has been revised (October 2003-January 2004), no false positives have been identified (0/3), but it is recommended that more recent data be collected in order to confirm this possible improvement. In contrast, the corresponding values for Highfield are higher, being 46% (16/35) with the original screening questionnaire (March 2002-October 2003) and 56% (10/18) with the revised version. These higher values raise questions about the linguistic and cultural impact of the WILSTAAR screen in Highfield. More detailed analysis could help to reveal whether the increase in false
positives in Highfield were more often associated with the non-English speaking families and the possible reasons according to the language used.

It is interesting to note that in the Leeds study, 29% of infants failed the initial screen, conducted in English\textsuperscript{15}. As many as 63\% (37/59) were later identified as false positives. However, in inner city Manchester, of 619 infants screened by health visitors, 29\% (N=182) also failed the screen (a similar value to that in Leeds), but as few as 37 (6\%) were identified as false positives\textsuperscript{12}. These two previous studies demonstrate substantial variation in the proportion identified as false positives.

A more challenging, but hidden outcome, could be of false negatives (infants in need of remedial action who have not been identified as such by the health visitor’s assessment). The present system does not allow any confirmation of these cases and their detection at a later stage would present an extra burden for health and educational establishments and distress for the infants and their families. Reportedly, there may have been a few recent incidents in which some health visitors failed to apply the screen with eligible cases. It is hoped that forthcoming research would highlight any special concerns in that area.

The role of the health visitor is key to so many aspects of child development assessment. Health for All Children, 4th edition\textsuperscript{16}, makes recommendations that will have major implications for the health visiting service, with a move away from the established child health surveillance programme. Implementation of Hall 4 is currently ongoing, but this will ultimately be succeeded by the National Service Framework. The extent to which these changes can accommodate an early intervention such as the WILSTAAR programme remains to be explored.

This study noted some problems in applying the REEL score, an issue also identified in the Leeds study\textsuperscript{15}. The authors felt that it needed rewording to make it accessible to parents. The REEL is a 27 year old assessment tool, of American origin, standardised on English-speaking children. Its applicability to non-English speaking situations must therefore be questioned.

The present study noted that children often passed the REEL via the parental report, but the therapists’ observations did not observe the features that the parent was claiming. A number of potential explanations have arisen in the present study, most of them more applicable to the South Asian families. Many of them could also apply to the screening questionnaire and include:

- Not understanding the question, either in English, or in its translated format
- Mistranslation, loss of meaning, words not able to be expressed clearly from English to, Urdu and Punjabi such as the concept and translation of words (e.g. ‘as much as’) and fine differentiation between words (e.g. 'hearing' and 'listening').
• The quality of the answer: a perception of the truth, obsequiousness bias\textsuperscript{17} or wishing not to admit to a particular situation for reasons of confidentiality (in the South Asian community).

• Not seeing the point of the questions or understanding the significance of the intervention.

It has also been suggested that infants may be quiet in front of strangers\textsuperscript{15}, and hence when observing the child in ‘an artificial situation’, speech therapists cannot match this with the carer's comments.

Internal evaluation of the REEL scores both before and after the programme are given for a sub-sample of the Keighley Sure Start population in Table 2. Comparisons are also made with the results of the Leeds study, where an experimental and control group were employed, the latter having received just the WILSTAAR summary sheet at the end of the first visit, while the experimental group's intervention included five home visits over four months\textsuperscript{15}. That study failed to demonstrate a clear difference between the two groups, although the extent to which an advice sheet may have 'contaminated' the results is unknown. This Keighley study did not use a control group. Comparative data within this study is therefore confined to variations between the white and South Asian infants. While the REEL score normally increases with age and would therefore be expected to become a higher value at the end of the three months, with or without an intervention, it is interesting to note how this relates to the results in Table 2. For instance, without a control group, it is impossible to judge whether the WILSTAAR intervention in the white population was a relative success, although the qualitative feedback would indicate that this is likely.

<table>
<thead>
<tr>
<th>Table 2: Results of internal evaluation: REEL scores at entry and on completion of the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guardhouse/ White (N=11)</strong></td>
</tr>
<tr>
<td>10 months</td>
</tr>
<tr>
<td><strong>Highfield/ Asian (N=10)</strong></td>
</tr>
<tr>
<td><strong>Asian with interpreter (N=4)</strong></td>
</tr>
<tr>
<td><strong>Asian without interpreter (N=4)</strong></td>
</tr>
<tr>
<td><strong>Leeds Community Study (1999) (N=22)</strong></td>
</tr>
</tbody>
</table>
Evidence may eventually be gained from a lower level of later referrals, as was reported in the original WILSTAAR studies\(^4\). However, a previous internal evaluation of 10 children who completed the programme in Guardhouse (2000-2002) confirmed the mean age at start as 10 months, with an average first Assessment Score of 74 and a final score of 99, very similar values to the present data for the white children.

Despite the limited sample size, comparison of data derived from the Keighley white and South Asian families indicates several important variations. The mean age at entry into the WILSTAAR programme and age at completion shows that South Asian children were, on average, three months older throughout. It is also interesting to note that on entry, the mean REEL scores are only 5 units apart (despite the age difference), and the South Asian infants have the lower scores. At the end of the programme, the difference between the two groups in relation to the final REEL score increases to 22. Overall, the South Asian infants’ mean REEL score had increased by 10, while that for the white children had increased by a value of 27. Even with the limited sample size, this result raises some important questions.

On average, the South Asian children were aged over 12 months at the time of entry into the programme. The reasons for this delay need to be identified. Initial identification of the age at which they were screened by the health visitor is a starting point, in order to determine the stage at which the delay has occurred. Of course, it is possible that the family or the child are not in Keighley but are visiting relatives when the child is due to be screened. There could have been limited availability of bilingual workers at that time. A longer period of time would also be required to complete the programme if the family go on an extended family visit whilst the programme is operational, or are not at home during arranged visits. However, it is not the duration of the programme, but the age at recruitment that has been identified as problematic.

Further assessment work is required with the application of REEL to South Asian families. Table 2 indicates that, although numbers are small, the relative delay identified appears to apply to infants with parents from both English and non-English speaking backgrounds, but the ‘improvement’ then achieved is greater among English speakers. There are many South Asian parents in the Highfield area who have good command of English and in these cases, the assessment and programme is usually administered in English to them. The questions asked to obtain the REEL need translating for non-English-speaking parents. The outcome depends on the skill of the bilingual support
worker, including the words that are not readily translatable (i.e. babbling). Bilingual families may present a special situation in that there may be a delay in the development of speech and language in children exposed to two or more languages even at this age. As previous WILSTAAR programmes have excluded all bilingual children and children with developmental delay, it is impossible to draw any further comparisons at this stage. It is possible that the whole programme is just not culturally appropriate within the Highfield area. Alternatively, the findings may truly confirm that there are a greater number of children with global developmental delay in the Highfield area. Background information also suggests that the proportion of children identified with special care needs is higher among the Pakistani community\textsuperscript{18}.

Beyond the issues relating to information being lost in translation for South Asian families, there are cultural issues, as well as the level of education and literacy of the main carer, assuming that a non-English speaking main carer is more likely to have lived and been educated in Pakistan. It would appear that those Highfield mothers brought up in England seem to have a greater appreciation of the reasons why speech and language therapists are trying to intervene at such a young age and they generally have a better understanding of the activities discussed. There are value systems inherent in the WILSTAAR remediation programme. Communicating the concept of 'at-risk', the value of concepts of prevention, basic concepts of play and the perceived value of an early intervention. A previous study of preventive attitudes between Pakistani and white parents indicated that the Pakistani families felt less empowered to intervene in terms of dental health behaviour\textsuperscript{19}. In addition, the small white families described in this study, where the mother is the sole carer who needs to be influenced to intervene, provides an important contrast to the South Asian households where there may be multiple carers.

Communication is a key issue. The process of informing parents can have a profound effect on their view of the support services and their ultimate compliance or willingness to use them. Effective communication is fundamental to establishing a positive relationship between parents, professionals and the child. The Leeds WILSTAAR study also indicated that, even when conducted in English, parental responses varied. Some parents were reported to be 'very eager' and others 'much less proactive'\textsuperscript{15}. In South Asian households, there may just be more people who need to be communicated with, and this is more time consuming. In addition, families may feel pressurised due to competing priorities in their lives, such as child protection and/or their own literacy levels.

From the user perspective, lack of perceived need for WILSTAAR programme may present a major barrier. Perceived need is a complex issue. It can incorporate lack of comprehension of the beneficial effects derived from the preventive procedures. Raising awareness at a conceptual level is a very challenging task and requires understanding of these key issues together with the
characteristic features of the community being targeted. A prerequisite to a successful programme would need to take into account the SALT's explanation about the child's at-risk status as perceived by these families together with their views on the credibility being given to the remedial effect of the programme and the extent of their willingness to get involved.

It is the linguistic and cultural differences that contribute to the additional disadvantage suffered by South Asian communities. Evidence from this study shows that non-English carers have poor understanding of the issues surrounding speech development. Therefore any delay in speech is not thought to have any serious consequences and they may fail to appreciate its impact on the child's emotional, behavioural, social and educational development. Such findings fuel the debate on whether it was the lack of understanding about speech therapy and the value of that service or lack of perceived need.

A few families do refuse to be recruited into the WILSTAAR programme. It is important to enquire as to their reasons for abstention from the programme, in accordance with the Government's guidelines highlighting the need for programme design to take account of the perspectives of the users, as their views are crucial to a positive outcome.

The Guardhouse area contributes only a small proportion of referrals to the WILSTAAR programme at present. The majority of referrals are from the South Asian community. However, if the programme were to be adopted across the Primary Care Trust so that all 8 months old babies were screened for risk of language delay, irrespective of socio/cultural background, then the impact on referrals has the potential to be very significant. The estimated two per thousand school children suffering from persistent severe speech / language impairments are at increased risk of developing behavioural, social and literacy difficulties. When the WILSTAAR project was introduced across the Trust in Bournemouth, 203/214 (95%) of children who completed the programme were judged to have gained full remediation of their language difficulties. This represents a large number of children who would have probably been referred to the service at an older age, and would have needed more resources to effect a change.

This study has highlighted some problems inherent in introducing the WILSTAAR programme to the South Asian community in Keighley. The potential for gaining benefit among the white community needs to be confirmed by expanding the study to include a larger geographical area. In the meantime, further internal evaluation should be undertaken with the South Asian community in this and other areas in order to identify which of the issues documented here best explain the variations observed.
CONCLUSION

Since the original version of the WILSTAAR screen was conducted on English speaking populations, this is the first study to evaluate its impact on other populations. The Keighley WILSTAAR speech and language programme achieved its aims in detecting, assessing and intervening where there was evidence of language delay. Data from the REEL assessment revealed that the WISTAAR screen is able to pick up cases with delay in speech. However the screen does not appear to be too specific and picks some false positive cases, especially among South Asian families. Once a delay is detected, the speech therapists appear to be making every effort to intervene in order to raise the profile of the children as reassessed by a REEL score at the end of the programme. Its efficiency seems to be dependent on the nature of the community being targeted. In relative terms, the remediation programme has failed to raise the performance of the children from the South Asian community.

A number of issues may inhibit the effectiveness of the service. These comprise the challenges inherent in the use of the WILSTAAR screen, including the technical aspect, and its inflexibility in not being able to incorporate any linguistic changes to make it more user friendly. There is also some cause for concern regarding the use of non health professionals to either conduct the WISTAAR screen or help professionals in the screening and subsequent assessment process. Certain cultural issues were also identified, for instance between professionals and non-professionals (e.g. with speech therapists and parents/guardians) and in relation to the South Asian culture.

Several factors influenced the efficiency of the WILSTAAR screening and home visiting service in relation to the characteristics of parents/carers. There were concerns about the parents'/carers' perceptions and hence their compliance and a lack of awareness of cultural expectations by health professionals.

The health visitors and HCSW reported having good general experience with the WISTAAR screen although only one was able to comment on its impact on the South Asian residents of Keighley. They were all concerned with the inflexibility of the linguistic component of the screen and had serious misgivings about the use of some of its questions.

Feedback from the health care support worker (HCSW) indicated that she was fairly confident with the use of the WISTAAR screen and that no further training was required. Her initial training consisted of one day and there had been no further update to enhance the technical knowledge.
The efficiency of the service could be improved through the recruitment and employment of fully qualified South Asian health visitors and speech therapists, the modification of WISTAAR screen to make it more user-friendly, health promotion to impact on users’ perceptions and better feedback to users to enhance their compliance.

There was a universal recognition of the usefulness of the WISTAAR screen among health visitors and speech therapists. They expressed a view that the programme should be extended to include the whole community (and not just Sure Start residents). There have been calls for mainstreaming of the WISTAAR programme across the district. While there is a merit in considering this approach, the potential for gaining benefit among the white community needs to be confirmed by expanding the study to include a larger geographical area. In the meantime, further internal evaluation should be undertaken with the South Asian community in this and other areas in order to identify which of the issues documented here best explain the variations observed.
RECOMMENDATIONS

WILSTAAR Screen:
Since Keighley is in a unique position to nationally pilot the WILSTAAR screen among South Asian residents. Most of the recommendations are based on the lessons learnt from this aspect of the programme regarding the early detection and remediation of the WILSTAAR programme.

1. The language of screen used for the identification of early delay has been considered too difficult and inappropriate for both English and non-English speakers and the professionals responsible for screening have expressed a need to make it more user-friendly.

2. The restrictive nature of the language used in the screening process requires the translation of the screening tool in each of the community language prevalent in the area and subsequent training programme to standardise its delivery.

3. The only bilingual (Urdu/English) health care support worker appeared to be too much burdened with the responsibility of conducting the screen and therefore further recruitment of the health care support workers from within the communities being targeted should be encouraged. Subsequent incentives should be designed to encourage their retention.

4. The comparison of the pre and post REEL scores for White and Asian users show clear variation. This highlights the need to further explore the factors contributing to the low level of progress resulting from the remediation process among South Asians and includes consideration of the applicability of the REEL measurement in this population group or the way it is delivered, carers' understanding and capacity for involvement, or the rationale for real differences in outcomes.

5. There are very few trained South Asians health visitors and speech therapists associated with the WILSTAAR and REEL assessment tools and their active recruitment may be required to address any errors at the diagnostic and assessment level.

6. There is evidence of appreciation for the WILSTAAR programme from both white and South Asians residents of the Sure Start zone and hence the patient support and empowerment programmes for parents/guardians to enable a better access to the services should be continued.
7. Health promotion programmes for parents/guardians are required to raise their awareness of the significance of early detection of speech problems. Attaining their cooperation for the remedial programmes should take religious, cultural and linguistic needs of the community into account. As the consequences of delay in speech of a child are experienced by everyone in the family, the siblings and members of the extended family should also be targeted by these programmes and community based health promotion programmes should be conducted in their language.

8. Raise awareness of all stakeholders, especially health professionals, of the cultural, conceptual and linguistic barriers which could hinder access of children and their parents to key remediation programmes.

9. All the WILSTAAR infants that have completed the programme should be followed up to school age and the corresponding foundation assessment recorded.

10. The examination of the pre and post REEL scores for the White community reveal that the programme is potentially beneficial in early detection and subsequent benefits accrued by the remediation programme and hence consideration should be made to extend its philosophy and practice into mainstream.

11. As both WILSTAAR and REEL have only been standardised on English speaking communities there is a need to perform similar standardisation for other sectors of the communities being targeted.

12. In order to meet the mainstreaming requirement there is a need to conduct some further research to explore and elucidate factors responsible for the differential progress attained from the WILSTAAR remediation programme among White and South Asian children.
REFERENCES

1. Sure Start Keighley Updated Delivery Plan (June 01)

**APPENDICES**

Appendix 1: WILSTAAR Screen – original version

Appendix 2: Flowchart to show the relationship among the WILSTAAR team

Appendix 3: Focus Group Schedules
   - Parents / Guardians
   - Health Visitors
   - Speech Therapists
   - Health Care Support Workers (HCSW)

Appendix 4: Further Detail of Participants

Appendix 5: Information
   - Parents / Guardians
   - Health Professionals / Health Care Support Workers

Appendix 6: Consent Forms
   - Parents / Guardians
   - Health Professionals / Health Care Support Workers

Appendix 7: Personal & Professional Data
   - Parents
   - Professionals

Appendix 8: WILSTAAR Screen – New version

Appendix 9: Summary of Sure Start Results
**APPENDIX 1**

**WILSTAAR Screen – Original Version**

Please place a sticker (if available) otherwise write in space provided

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer:</td>
<td>Administered by:</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Designation:</td>
</tr>
<tr>
<td>DOB</td>
<td>HV Support Worker</td>
</tr>
<tr>
<td>Sex:</td>
<td>Other:</td>
</tr>
<tr>
<td>Address</td>
<td>Location:</td>
</tr>
<tr>
<td>Postcode</td>
<td>Clinic</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Home</td>
</tr>
</tbody>
</table>

**Interpreters Needed for Main Carer?**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>If Yes Language?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Punjabi</td>
</tr>
</tbody>
</table>

To be administered before any screening test (or questionnaire) of hearing

Please tick Yes or No for each question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Does s/he always notice sound like people coming into the room or food preparation sound?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2  Does s/he always notice when you call his/her name when s/he’s not really concentrating on play?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3  Does s/he notice cars passing, dogs barking, the hoover, as much as ever?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4  Does s/he ever ignore interesting or unusual sounds?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4b Would s/he always turn a second time to an interesting sound like the rattle of a biscuit tin, if it came again soon after the first time?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5  Have you ever, at any time, thought s/he might have hearing loss?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6  Does s/he string different sounds together now e.g. “ba de do dee dye”?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Please return all completed questionnaires to SALT, KHC
APPENDIX 2

Flowchart to show the relationship among the WILSTAAR team

Key:
- W: WILSTAAR programme
- HV: Health Visitor
- SALTs: Speech & Language Therapists
- HCSW: HCSWs
- REEL: Receptive-Emergent Expressive Language

*: if advice not followed, reason for this explored, programme given again in a different format if necessary, e.g. Tape, different visits arranged between those shown on the flowchart

1. HV and parent/carer
2. W Screen by HV or HCSW
3. All screening questionnaire forms sent to SALTs for scoring
   - Pass
     - HV informed of outcome
     - No longer part of W programme
   - Fail
     - HV informed of outcome
     - Home visit 1
     - SALT full assessment
     - √ Child observation
     - √ REEL
     - REEL score > 86
       - False positive summary sheet given
       - No further contact, HV informed
     - Reel score < 86
       - True positive begin W 1st programme given
4. 2 weeks later...
   - Home visit 2:
     - SALT checks whether advice has been followed*
     - Give second programme
5. 4 weeks later...
   - Home visit 3:
     - SALT checks whether advice has been followed*
     - Give third programme
6. 4 weeks later...
   - Final home visit 3:
     - SALT checks whether advice has been followed*
     - SALT administers final assessment
    - REEL score > 86
      - Good result
      - Summary programme given
      - Case closed
    - REEL score < 86
      - Child still has delayed language development
      - Stays on SALT caseload
      - Offered a language group when 2 years old
8. HV informed of outcome
APPENDIX 3 (a)

Focus Group Interview Guide for Parents/ Guardians:

General Awareness of Sure Start:

- Do you know what Sure Start does in your area?
- Who is it designed to help and support?
- What are the benefits of Sure Start?
- Have you heard of Sure Start before this session?
  - If yes, do you know of any activities planned through your local Sure Start?
    (If necessary prompt them with examples of some of the local sure start activities)
  - Have you been invited to join Sure Start?
  - If you refused could you please tell me about your concerns?

General Awareness of WILSTAAR

- Do you know who WILSTAAR project is designed to help?
- How do the health professionals get hold of you?
  (eg telephone or personal visits)
- Are you happy with the way they contact you?
- If not? Please tell us the reasons.
  (Probe them on convenience, privacy and confidentiality matters).
- How do you think your child may benefit from the scheme?
- Do you think there may be any benefits of the programme for the older children as well?
  - If so what could they be?
- Do you think there might be any benefits for the family as a whole?
  - If so what could they be?
    (Probe the socio-dynamic factors and its perceived impact on the social, emotional
and educational welfare of the child).
- Are the instructions given by the health professionals easy to follow?
  - If yes, have they helped to improve your relationship with your child?
- Apart from the Speech & Language Therapy Team, has any one else approached you regarding
the language development of your child?
- If you communicate through HCSWs, are you happy with the service?
  - If not, what are the concerns?
- Have you ever consulted the team about anything else regarding the welfare of the child?
- Have you ever consulted the team for anything that is not related with the WILSTAAR
programme?
  - If yes, what was that about?

Communication:

- Do you understand the principles of WILSTAAR?
- If yes, who explained and how?
- Do you need anyone to help you communicate with the health professionals (speech therapist
and health visitors)?
  - If yes, who helps you?
    (Discuss the appropriateness of these measures)
- Can your child understand the health professionals?
  - If not, how do the speech therapists and health visitors manage?
    (Discuss the appropriateness of these measures)
✓ Prior to starting the WILSTAAR programme did anyone ask your permission to take part, or check whether you would like to be part of this programme?
  ○ If not, what were your worries?
✓ In order to make the service better would you like me to explain any points to the service providers?

Thank you very much for your giving me your time and help.
APPENDIX 3 (b)

Focus Group Interview Guide for Health Visitors

General:

✓ When do you see the mother and the child for the first time?
✓ When do any successive visits take place?
✓ How long is each visit for?
✓ Where do you see the mother and infant?
✓ How many visits you make for each child?
✓ Where do you obtain your birth information?
✓ What are your views on Sure Start services?

Sure Start and WILSTAAR:

✓ I understand you are asked to apply the WILSTAAR screen for the children resident in Sure Start areas. How do you know which postal codes are for Sure Start residents?
✓ Did you receive any special training for the WILSTAAR screen or have you had other aspects of WILSTAAR fully explained to you?
   ○ If yes, can you tell me something further about it?
   (In what form and how long for?)
✓ As far as you are concerned what are the perceived benefits of WILSTAAR for users?
   (Ask them to elaborate)
✓ What do you perceive its significance for service providers?
   (Ask them to elaborate especially in terms of Sure Start)
✓ What are the perceived benefits for your own personal or professional development?
✓ How does it fit into your routine?
   (Discuss its convenience and their personal satisfaction rating?)

Communication:

✓ Who is responsible for the application of the WILSTAAR screen?
✓ Where does it take place?
   ○ (Clinic or domestic, for example?)
✓ During your domestic visits are there any distractions (family members, visitors etc.)?
   ○ If yes, how do you overcome them?
✓ When dealing with parents are there any communication problems?
   ○ If yes, what are they? and
   ○ How do you cope with them?
✓ How are the language needs of BEM (Black Ethnic Minorities) addressed?
✓ If using HCSWs, are you satisfied with their service?
   ○ If not, what are the concerns?
   (Ask them to elaborate esp. regarding their mutual trust, cross cultural communication issues, perceived benefits to the users etc.)
✓ How do you process your findings?
   (Internal recording, info sharing with other professionals, who are they? Their relationship with the SALTs? How often do they exchange info? Is there any special format or general reporting? Do they receive any feedback from SALTs?)
✓ Can you suggest any ideas, which will help to improve the service?

Thank you very much for your help and time.
APPENDIX 3 (c)

Focus Group Interview Guide for Speech Therapist:

General:

✓ What is the role of WILSTAAR within Sure Start?
✓ How does the geographic spread of the children identified in need of language support therapy affect the workload of the therapists working for the sure start scheme?
✓ How do the other members of the management team fit into WILSTAAR?
✓ What does the SALTs training entail?
  (Discuss in terms of its entry requirement and duration)

WILSTAAR:

✓ How do you think the users benefit from the WILSTAAR programme?
✓ Can you identify any evidence of such benefit from your personal experience?
✓ Where do you obtain your referrals?
  (Discuss the format of the referrals)

Communication:

✓ On making a contact with the parents, who makes the first approach?
✓ Do you obtain parents'/ guardians' consent?
  o If yes, is it in verbal or written form?
✓ Are there any special communication issues when dealing with the users?
  o Special needs, that of parents/guardians' or children's?
  o Linguistic needs?
    ▪ How are they overcome? (e.g. is language support always available?)
    ▪ Are you satisfied with these measures or would you recommend any improvements?
✓ If using HCSWs, are you satisfied with their service?
  o If not, what are the concerns?
  (Ask them to elaborate esp. regarding their mutual trust, cross cultural communication issues, perceived benefits to the users etc.)
✓ Are there any special communication issues when dealing with the professionals?
  o From whom, how and in what form is the info received?
  o What happens to the info collected by SALTS?
  (Discuss in terms of internal processing and referrals)
✓ Are there any refusals and non-responses?
  o If yes, how are they tackled?
  (e.g. how many approaches before discarding the case or what are the strategies for dealing with non-interested parties?)
✓ What is the refusal rate?
✓ Who is responsible for application of the WILSTAAR screen?
✓ Can you describe the setting?
✓ Are there any distractions?
  (Family members, visitors, television etc.)?
✓ How do you process your findings?
  (E.g. internal recording, info sharing with other professionals, who are they? Explore their relationship with the health visitors, audiologists etc?)
  How often do they exchange info?
Is there any special format for reporting? Do they provide feedback to health visitors?)

✓ Have the parents or guardians ever sought your advice for anything other than the welfare of their child?
   (Without jeopardising the confidentiality of the individuals ask them to elaborate the nature of the advice dispensed).

✓ Are there any regular attempts to internally evaluate the WILSTAAR initiative?
   o If yes? Who normally contributes to it?
   o What is the outcome of the findings?

✓ Can you suggest any reasons for the lack of data regarding false positives in Highfield compared with Guardhouse?

✓ Can you suggest any ways of overcoming this gap and improve the service?

(Probe them on the appropriateness of resources & user compliance)

Thank you very much for your time and help.
APPENDIX 3 (d)

Focus Group Interview Guide for HCSWs (HCSWs):

General:

✓ Who employs you?
✓ Can you highlight any benefits of Sure Start for the community?
✓ What do you see as your role in helping the users make the most of any benefits of the Sure Start services?

WILSTAAR:

✓ Do you understand why WILSTAAR is useful for children and families?
✓ How long have you been involved in the WILSTAAR programme?
✓ What is your role in this programme?
✓ Do you always accompany health professionals for WILSTAAR visits?
  ○ If no, do you ever make any independent visits?
    ☆ What do these visits involve?
✓ Have you received any special training for WILSTAAR and what did that entail?
  (Discuss in terms of the appropriateness of the training for the expectations of the job.)
✓ In this context do you need any further training?
  ○ If yes, what should it be?
✓ Are you familiar with the language /dialect of the parents?
  ○ If not, can you share some problems with me?
✓ Can you describe parents’/guardians’ aspirations and ambitions associated with the physical, emotional, intellectual or spiritual development of their child?
✓ What are the parents’/guardians’ views about the usefulness of the WILSTAAR service?
✓ When dealing with the parents in the home setting are there any distractions?
  ○ If yes, how do you cope with them?
✓ Are there any cross-cultural issues that you find difficult to discuss with the health professionals?
✓ Do you get the opportunity to discuss with the health professionals any implied messages, which might have been difficult to translate during interpretation?
✓ Can you make any suggestions for parents/guardians to improve their participation in the programme?
✓ In order to improve the service are there any suggestions for the WILSTAAR team.

Thank you very much for your time and help.
APPENDIX 4

Details of interview participants

Health Visitors: A group of eight English health visitors with varied experience of the WILSTAAR programme (8 months to 2 years) were requested to take part in a focus group. The group was organised by speech and language therapists and convened in Keighley Health Centre. They had no personal experience of working with ethnic minorities and hence that aspect of the service was followed up by a one-to-one interview with an English health visitor and her assistant working in the Highfield area of Keighley.

Health Visitor Working with Ethnic Minorities of Keighley: The health visitor responsible for WILSTAAR screening of ethnic minorities had been associated with a local general practice for the past 4 years. Her assistant support worker was responsible for 99% of the screening whereas she dealt with the rest of the difficult and sensitive cases. The interview was conducted at Dr. A’s surgery.

HCSW: S*S was employed by Airedale PCT (14 years). She had been associated with Dr. A*A surgery and for the past 4 years had worked as a HCSW. As a qualified interpreter, she holds an NVQ level 4 certificate and has had plenty of experience working with the South Asian community.

Speech Therapists: A group discussion involving 5 speech therapists (one Bengali and 4 English) was convened in Airedale General Hospital. With varied work experience ranging from 2 to 32 years in speech therapy, their WILSTAAR experience ranged from 3 months to 2 years.

White Parents: White parents (5 single mothers, age range 23 to 36 years) who had been users of WILSTAAR programme were interviewed in a group situation. The session was organised by the Sure Start team and the group convened in a local community centre in Guardhouse where refreshments for parents and small gifts for children were also provided. The list of names was supplied by the principal speech and language therapist, according to parents’ availability and desire to be interviewed.

Asian parents: Attempts to organise a focus group with this sector of the community failed to materialise and hence the parents were accessed and interviewed at home. Four parents (three mothers and one father, age range 27 to 31 years) were interviewed on a one-to-one basis in Punjabi, Urdu or English as appropriate. The list of names was supplied by principal speech and language therapist according to their availability and desire to be interviewed.
APPENDIX 5 (a)

Information for Parents/Guardians:

Dear Parent/Guardian

I am a researcher working with the University of Leeds. I am trying to find out about the sure start services in Keighley and would like to know whether local people are happy with the activities they have planned for your benefit.

If you have a child under 4 years of age who is either in the process of receiving some speech therapy from the WILSTAAR programme now or has done so in the past then I would like to invite you to a group discussion. The group discussion will be held in one of the local community centres. It will last for approximately an hour. For your convenience we will provide you with buffet lunch and child care, if required.

You will be approached by either myself or my colleague Julia Csikar. We will give you a chance to air your views and share your experiences with other parents and guardians whose children have had some speech problems. There is no right or wrong answer and everyone’s opinion is equally important. We also need to gather some personal data such as your contact details and the child care arrangements. All the details collected will be completely anonymous and will only be used by the research team to assist with report writing. You will be given a chance to answer any queries that you may have regarding our research.

Thank you very much for your assistance

Mrs. Abida Malik
Research Fellow
Leeds Dental Institute
University of Leeds
Clarendon Road, Leeds LS2 9LU

Tel: 0113 2336181/ 0113 2336197
APPENDIX 5 (b)

Invitation and Information for Health Professionals/ HCSWs:

As part of evaluation of Sure start activities a research team from University of Leeds is trying to find out whether local services designed to meet the needs of babies, young children and their families are adequately serving their purpose. If you are engaged in WILSTAAR assessment, whether during health visiting, identification of speech/ language delays, assisting parents during the remediation process or provide language support for the health professionals I would like to hear your views regarding the service delivery and any concerns you may from the users of the service. The data collected will remain anonymous. The results will help to recognise good practices as well as identify changes, which might be required to enhance the quality of the service.

You are cordially invited to take part in a focus group. You will be provided with refreshments. We are of course happy to explain our role in WILSTAAR.

Dr. Abida Malik
Research Fellow
Leeds Dental Institute
University of Leeds
Clarendon Way, Leeds LS2 9LU

Tel: 0113 2336181 / 0113 2336197
Email: a.malik@leeds.ac.uk
APPENDIX 6 (a)

Consent Form for Parents/ Guardians:

Name of Researcher:  Mrs. Abida Malik

Please tick boxes

1. I confirm that I understand the information, which has been given to me and have had the opportunity to ask questions. [ ]

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason [ ].

3. I agree that my contact details can be shared within the research team for the purposes of this project alone [ ]

4. I agree that I can be contacted for any further information about the discussion regarding WILSTAAR Service by the above named researchers. [ ]

_____________________           ________________      _______________
Name of Person Date Signature

_____________________           ________________      _______________
Researcher Date Signature

Contact details:

Home address:

_______________________________________________________

Home telephone number/mobile telephone: __________________________

Thank you very much for your help.
APPENDIX 6 (b)

Consent Form for Health Related Staff:

**Name of Researcher:** Dr. Abida Malik

**Please tick boxes**

- I confirm that I understand the information, which has been given to me and have had the opportunity to ask questions. [    ]
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason [    ]
- I agree that my contact details can be shared within the research team for the purposes of this project alone [    ]
- I agree that I can be contacted for any further information about the discussion regarding WILSTAAR Service by the above named researchers. [    ]

_____________________           ________________      _______________
Name of Person  Date  Signature

___________________           ________________      _______________
Researcher  Date  Signature

**Contact details:**

**Job Title:**

**Organisation:** _______________________________

**Contact Details:** _______________________________

Telephone number/mobile telephone: _______________________________

Thank you very much for your help

APPENDIX 7 (a)
Personal Data of Parents/ Guardians:

**Personal details:**

Name .................................................................  ID Code: 
Date of birth _____ / ____ / 19 ____
Age____

1. How many children do you have? .................................

2. What are their ages? ...................................................

3. Are you registered with Sure Start Keighley? ......................

4. Does anyone in your home have special needs?
   No □
   Yes □ if yes, please specify who and how this affects daily life
   ..................................................................................

5. Who usually looks after your children during the day? (*Tick as many boxes that apply*)
   Mother at home □₁  Father at home □₂
   Sister/brother □₃  Child’s grandparent □₄
   Other relative □₅  Friend/neighbour □₆
   Paid childminder □₇  Nursery school □₈
   Day nursery □₉  Playgroup □₁₀
   Other □₁₁ .............................................................

6. Who lives in your family home? (*Tick as many boxes that apply*)
   Mother □₁  Father □₂
   Mother and father □₃  Mother and stepfather □₄
   Father and stepmother □₅  Grandparents □₆
   Other relatives □₇  Please specify..........................................
   Other □₈  Pease specify.....................................................

7. How many children are living in your house now? ......................
8. What is your marital status?
   Married □₁ Single □₂
   Divorced / separated? □₃ Widowed □₄

9. (i) What is your occupation? .................................................................

10. (ii) What is the occupation of your spouse? ...........................................

11. What is the postcode of your home address? ...........................................

12. At what level did you finish your full-time education?
   Primary school □₁ Secondary school □₂
   Further education (college) □₃ Higher education (university) □₄
   No formal education □₅
   Other □₆ please specify ..............................

Thank you very much for your help
APPENDIX 7 (b)

Personal Data of Health-Related Staff:

Personal details:

Name ................................................................. ID Code: □ □

Post with Relevant Grade: ........................................
Organisation/Department: ....................................... 

1. How long have you worked in your present post? ...........................................

2. How long have you had the experience of working with the WILSTAAR programme?

4. Have you had any training regarding:
   (a) Technical aspect of WILSTAAR (please specify): ........................................
   (b) Cultural and linguistic aspect (please specify):
       ..............................................................

5. Do you have any training need in relation to WILSTAAR? Please specify.
   ..............................................................

6. Would you be willing to answer any specific questions regarding the service delivery?
   If so please provide your contact details as follows:

   Name: ..............................................
   Post: .............................................
   Address: ............................................................................................................
   Work Tel: .............................................. Mobile
   ` ..............................................................
   Email: ..............................................

Thank you very much for your help
APPENDIX 8:

New Version of WILSTAAR Screen

<table>
<thead>
<tr>
<th>WILSTAAR</th>
<th>SPEECH AND LANGUAGE THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREENING QUESTIONNAIRE FOR ALL 6-9 MONTH BABIES LIVING IN GUARDHOUSE • BRAITHWAITE • HIGHFIELD</td>
<td></td>
</tr>
</tbody>
</table>

- **Name of child:**
- **DOB:**
- **Sex:** M □ F □
- **Name of carer:**
- **Telephone:**
- **Interpreter needed?** Yes □ No □
- **Language:** Punjabi □ Bangla □ Other:.................................
- **Address:**
- **Postcode:**
- **G.P.:**
- **Date of Questionnaire:**
- **Examiner’s Name:**
  - **Role:** H.V. □ H.C.S.W. □ C.S.N. □

Tick YES or NO for each answer or DK if carer is unsure

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career unsure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Does s/he always** notice sounds like **people coming into the room or food preparation sounds?** [ie. interesting sounds]

2. **Does s/he always notice when you call his/her name when s/he’s not really concentrating on play?**

3. **Does s/he notice cars passing, dogs barking, the hoover, as much as ever?**

4. **Does s/he ever ignore interesting or unusual sounds?**

   If yes ask 4b If no go to Q5

4b. **Would s/he if not concentrating on something else?**

5. **Would s/he always turn a second time to an interesting sound like the crinkling of a crisp packet, if it came again soon after the first time?** [Use an example relevant to the family]

6. **Have you ever, at any time, thought s/he might have a hearing loss?**

7. **Does s/he string different sounds together now e.g. baa dee goo daw bay?**

8. **Would you like a Sure Start Worker to come and visit?**
   - [Give some examples of what Sure Start could offer]

**Other information** (e.g. referred to audiology, home circumstances, health professional involvement)

- ☺ Thank you for your continued support of this early intervention scheme ☺

Please return all completed questionnaires to Wilstaar, SLT, KHC.
APPENDIX 9

Summary of Sure Start Results - Users’ Perspectives related to Sure Start Activities:

There were a variety of views expressed about the Keighley Sure Start programme. Health professionals saw it as very beneficial, a 'wonderful, superb project', but thought that it increased inequalities because it excluded needy areas outside the geographical area. Also they felt that many of the Asian families were unaware of it and what it had to offer. They felt that the publicity could be improved as not many of the leaflets had been translated.

Some of the carers were very enthusiastic. The South Asian parents stated that it was 'very good for Asian ladies'. They explained that they had received help with safety equipment (fireguard, fences, stair gate, smoke detector), that there is a nursery and toys, home visits for children, organised trips, English language classes - they were 'very happy'. However there was 'nothing for men'.

Some white parents valued the opportunity Sure Start gave them to meet other people; particularly for themselves as single parents meet each other; 'to go to the crèche to get a break’. They valued the support network it offered. 'I enjoyed it, getting her out to the play area'. ‘All the toys, she loves it and she's come on.’ There were open days. One mother had joined the Parents Group.

A few white mothers reported that 'people don't always know what is going on'. Some had received a newsletter, others had not. They were not sure what was available for parents, but there used to be computer courses. One had felt unwelcome at 'drop-ins', found them to be 'cliquey' and felt 'a bit out of it'. Another said that 'They promise and don't deliver', referring to subsidised driving tests that were no longer available - an issue also raised by one of the Asian parents.

Therefore the barriers to access for the Sure Start service by the parents/guardians can be summarised as follows:

- Lack of publicity
- Access issues
  - Transport
  - Competing priorities
- Cultural issues
- Linguistic issues

Lack of financial/manpower resources as displayed by their impact on continuation of some of some of the services such as driving lessons and computer classes.