Redesigning a speech and language therapy service in a school for emotional, behavioural disorders: perspectives of service users

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Abstract

This project takes a whole systems view of the challenges and opportunities for individuals working towards integration for children with speech, language and communication needs. The context involves collaboration across mental health and special education, to improve vocabulary outcomes for children attending a school for emotional, behavioural disorders. The facilitator of this project (student) viewed collaboration from a multilayered perspective, incorporating children, parents, school staff, operational and strategic levels of collaboration. Policy and the literature will be summarised to explore effective models of collaboration. Consultation with service users and the workforce led to the development of a whole school language approach, designed around the needs of children and their families. The facilitator used The HSE model (2008b) as an effective framework to analyse the change process. The facilitator adopted an action research methodology, alternating cycles of reflection and action. Evaluation involved multiple stakeholders in health, education sectors and service users providing feedback to inform further planning. This involved evaluation of SMART aim and objectives, in order to effect changes in the educational system. There are implications of this action research at clinical, research and policy levels. Children, parents and the wider workforce can effect changes in systems to mitigate the negative trajectory of speech, language and communication effects on all aspects of children’s lives. The key is making the interdependent journey together, adopting shared responsibility for communication impairment.
The author would like to acknowledge all those who contributed their time, effort and expertise to this organisational development project. The children, parents and school staff were core participants in this project and were key players in re-designing a speech and language service at school that reflected their needs. School staff made extra efforts to support children with language activities throughout the duration of this project. School and clinic management facilitated engagement with service users by supporting ethical approval. In particular, thanks to the Programme Director at RCSI, Steve Pitman who facilitated seminars throughout the year. Thanks to Liam Duffy who guided the action learning sets, which allowed the facilitator time and space to reflect, plan and design the project. Thanks to the members of the action learning sets who provided support at critical times. The entire process facilitated self and organisational transformation which will improve outcomes for children with speech, language and communication needs.
Chapter 1: Introduction

1.1 Introduction

The purpose of this organisation development project is to redesign a speech and language therapy service according to the service user needs in a special school setting. Chapter one will outline the aim and objectives of the project, the context of the organisation and the rationale for change. The facilitator will elaborate on the role adopted in the organisation and change process and will then proceed to the proposed organisation impact and potential threats to implementing the change. Chapter two will position the project in the context of a literature review. Chapter three will outline the HSE change model (HSE, 2008b) as a framework for the design and implementation of the organisational development and to highlight the multidimensional aspects of the change. Chapter four will evaluate the project by analysing multiple stakeholder questionnaires. The final chapter five will discuss the organisational impact, strengths and limitations of the project and clinical, research and policy implications. The project will commence with an outline of the aim and objectives:

1.2 Aim and Objectives

The aim is to redesign a speech and language therapy service in a school for children with emotional and behavioural disorders.
Parents, children and school staff will inform the creation of a high quality, accessible, equitable speech and language therapy service, designed around the needs of children and their families. The aim of the speech and language therapy service is effective health promotion, ensuring that all children can access communication support in a timely accessible way. The SMART objectives outline what will be achieved following the implementation of the change (Locke, Latham, Smith, & Wood, 1990).

1.2.1 Objective One

Measure five children’s language and communication skills using standardised assessments in November 2011.

1.2.2 Objective Two

Evaluate the views of five children, their parents and school staff in focus groups on how best to meet speech, language and communication needs at school in December 2013.
1.2.3 Objective Three

Implement changes to service delivery according to children’s, parent’s and school staffs needs from January to March 2014

1.2.4 Objective Four

Evaluate the effectiveness of service delivery changes by consulting multiple stakeholders in March/April 2014.

1.3 Context

The facilitator works in a large child and adolescent mental health service, run by the Hospitalier Order of St. John of God, and funded by the HSE. The service provides comprehensive mental health services to children and their families in south county Dublin, Dublin West and County Wicklow. The role of the facilitator in the organisation is Senior Speech and Language Therapist, responsible for assessing, diagnosing and treating disorders of communication in outpatient teams and a special school for emotional, behavioural disorders. This role involves working in both health and education sectors which are segregated sectors with unique cultures, processes and structures.
The facilitator is accustomed to a multi disciplinary team approach to working with
children with mental health difficulties. Education staff are experts in the curriculum
and engage with mental health professionals through written communication and
meetings. This dual role in education and health is challenging as there are few
structures in place to support interagency work, resulting in inadequate
communication between agencies and fragmentation of services.

The facilitator works two days per week in the special school. This role is funded by
the HSE who approached the Director of the child and adolescent mental health
Service to allocate a part time Speech and Language Therapist in the school.
Speech and language therapy managers supervise this role in the mental health
service. Children attending the school are under the supervision of Consultant Child
and Adolescent Psychiatrists and mental health teams. All children attending the
school have emotional, behavioural difficulties. The Irish National Educational
Psychological Service (NEPS) defines emotional, behavioural difficulties as
“difficulties which a pupil or young person is experiencing which act as a barrier to
their personal, social, cognitive and emotional development” (NEPS 2010: 4). These
difficulties encompass a broad spectrum of deficits including depression, anxiety,
psychosis, attention deficit hyperactivity disorder, oppositional defiant disorder and
conduct disorder. The National Council for Special Education (NCSE) report that one
in five students experience emotional, behavioural difficulties during their school life
(NCSE, 2012).
NCSE data report that Ireland has about one hundred special schools, twelve specifically for students with emotional and behavioural difficulties (NCSE, 2012). These schools cater for children who have disengaged from mainstream school due to the severity of their difficulties.

The special school consists of

- Forty five students, aged six to fifteen years, forty three boys, two girls
- There is an over representation of children from lower socio-economic groups
- 75% of the children and their families attend child and adolescent mental health services
- 17% of the children are in care, living in care homes or foster placement with relatives
- Seven classes consist of an average of six children per class, two Special Needs Assistants and one teacher
- In total there are seven class teachers, one resource teacher, and fourteen Special Needs Assistants
- The school management board comprises of the school principal, the medical director of the local mental health service, two parents and one previous principal of the school
The term “service user” refers to the children attending the school and their parents/guardians. The proposed organisational development project seeks service user involvement in order to address historical inequities in speech and language therapy special school provision. This project involves a paradigm shift in power relations between facilitator, mental health professionals, school staff, children and parents. Traditionally, the expert model has been employed in speech and language therapy and mental health, which fails to address the unique experience each service user brings to the therapeutic milieu. Culture, ethnicity, religion, family beliefs, gender, socio-economic status must be considered in order to facilitate mental health recovery (Buckely, Devitt, Gavin, Guerin, & Noctor, 2012). These considerations are the essence of true partnership- incorporating young people’s views to co-create a modern, effective mental health service (Buckley, Devitt, Gavin, Guerin, & Noctor, 2012). Additionally, severe economic constraints on the system require effective collaboration and commissioning to make savings by improving efficiency, avoiding duplication and gaps (Gascoigne, 2012).

Schools have an important role to play in supporting speech, language and communication skills at universal and targeted levels (RCSLT, 2009). Therapists can adopt a public health approach to ensure all children can access the communication support they need. Adopting this approach prevents a vortex effect of children referred onto specialist services. Universal approaches incorporate training and collaboration with the wider workforce to ensure that all systems around the child are skilled in responding to their needs.
A partnership approach evolves with the wider workforce and service users to ensure effective collaboration across the ecosystem.

1.4 Rationale for Change

The rationale for this project was driven by health legislation and the lack of systematic use of service user’s perspectives in the educational and local mental health systems. National policy on mental health- A Vision for Change (DOHC, 2006) puts service users at the centre of mental health services. In this policy, a chapter is devoted to seeking service user’s perspectives on planning and implementing service delivery in mental health. Eight years later, the recommendations have not been implemented, and the process of change has been slow. Health Service Executive corporate and service plans recommended incorporating service user’s views in designing an effective modern health care system for over a decade (HSE, 2005, 2008a, 2013, 2014). The National Strategy for Service User involvement in the Irish Health Service (DOHC, 2008) advocate for service user involvement to enable people to become actively involved in making decisions about their lives and work collaboratively with professionals to develop and deliver services.
The current system is traditional, deferring to expert professionals to make decisions about children’s lives. Young people’s voices are seldom sought, particularly those with mental health challenges (Flynn, Shevlin, & Lodge, 2012).

Additionally, within the speech and language therapy department, there was a drive towards providing universal and targeted services to children attending special schools for emotional, behavioral disorders. Service users are central players in service re-design. The facilitator consulted Teachers, Special Needs Assistants and school management, in order to collaboratively redesign a service that incorporated their views. Using an ecological approach, change in one part of the system affected change in other parts of the system. The HSE model of change (2008b) was an effective reference point to envision changes across the eco- system.

1.5 Role of Student

The role of the student in this organisational development initiative was as a facilitator of service user involvement and enabler of change in the educational system.
Thus, the term “facilitator” will be used to refer to the student throughout this project. Adopting a facilitator role enlisted partnership, participation and empowerment in the change process. Additionally, the facilitator adopted an insider researcher role, conducting joint reflection and inquiry with school staff and exposing self inferences and opinions to critique (Coghlan & Brannick, 2009). Self awareness and self exposure were critical leadership skills necessary to drive the change effort (Reflection diary, p.6-7).

1.6 Organisational impact and expected outcomes

Stakeholders in this proposed change refer to the children, parents, school staff, school management and child and adolescent mental health professionals. The adoption of the HSE Change Model (HSE, 2008b) will ensure effective collaboration, empowerment and engagement across the system, which can be continuously monitored in order to ensure that partners do not step back into traditional roles and practices. As there is already a system in place with limited provision of speech and language therapy in the school, further service user changes can be facilitated by building on small successes, and motivating staff to continue working in integrated, consolidated ways. The change project will involve intangible cultural, and tangible behavioural and personal outcomes.
Qualitative outcomes will evolve from the whole school language approach involving meetings, training, children's vocabulary groups and liaison between facilitator and school staff. Quantitative outcomes will relate to feedback from multiple stakeholder questionnaires, systemic and structural changes in the school.

1.7 Potential threats to implementing the change

Kotter (1995) emphasises removing obstacles to a new vision by empowering others across the organisation. There is a lack of consensus in the school on the value of sharing power with service users in service design and delivery. Cultural, power and political dynamics will play out in the system during the implementation of the change project. These complex multi-faceted issues need to be considered to ensure long term sustainable change. The cumulative effect of combined social forces exert a much greater effect than individual factors (Jensen, 2013) The facilitator is optimistic that creating short term wins will motivate staff to continue working towards a shared vision of change. Moreover, clear planning, communication, and networking with stakeholders will negotiate coalitions of support to manage intangible aspects of change. Advocacy of service user needs will need to be embedded in the culture of the school. This paradigm shift will be challenging given the current context of budgetary cuts, decreased staffing levels and increased organisational stress at changes to working hours and conditions.
1.8 Conclusion

This chapter advocated for service user involvement as it fits well within the mental health context. There is shared understanding of the need for partnership, participation and empowerment in the recovery process. The challenge is to restructure the system, giving service users a voice on speech and language service delivery in a special school. The change process involves a paradigm shift away from an expert model to a distributed leadership model for effective change. The organisation development project will explore what service users want to envision in a speech and language therapy system. The facilitator will draw on professional training and experience in promoting effective communication skills and a lifelong belief that shared responsibility for change and recovery offers the best outcomes for children with communication and mental health challenges. Chapter two will proceed to discuss the incorporation of service users in planning services and a review of service delivery models in education. The literature review will ensure that the change initiative is in line with current evidence based practice.
Chapter 2: Literature Review

2.1 Introduction

This literature review will outline the purpose and levels of service user involvement, proceeding to service user involvement in speech and language therapy and education settings. Models to effective collaboration in the educational system will be discussed and analysed in the light of previous and emerging research. The facilitator will discuss challenges and opportunities to effective collaboration in the context of integrated service delivery. This interdependent journey of service user, education, mental health and speech and language therapy services incorporates a broad literature base. This subject spans the literature of mental health, speech and language therapy, and education. The search was conducted using CINAHL, Medline and Psychinfo databases. The review was restricted to articles written in English in academic journals in the last ten years. The facilitator selected forty six articles out of one hundred and twenty results. The terms used in the search were:

- Pupil voice and emotional behavioural disorders
- Whole school communication support and speech and language
- Collaboration Teachers and Speech and Language Therapists
- Power and participation in child and adolescent mental health
- Speech and language and child psychiatry
2.2 The purpose of Service User involvement

The Bercow review of service provision to children with speech, language and communication problems in the U.K., has service users at the centre of its recommendations (Bercow, 2008). The review stressed the need for a continuum of universal, targeted and specialist services designed around young people involving joint commissioning between health and education. Commissioning is the process for deciding how to use resources in order to improve outcomes in efficient, effective, equitable and sustainable ways (Commissioning Support Programme 2011). The comprehensive Bercow review has highlighted that commissioning services for children with these needs is complex (Bercow, 2008). Organisations are required to work with service users to understand local population needs, resources available, plan sustainable services, and monitor and evaluate service delivery outcomes (Commissioning Support Programme, 2011). All children and young people can communicate and contribute to decisions about services affecting their lives including children with speech, language and communication needs.

Involvement in decisions is a basic human right. Lundy (2007) asserts that listening to children’s views is not just good pedagogical practice but a legally binding obligation.
Service user involvement can help commissioners to understand the needs and outcomes service users would like to see as a result of service delivery (Lyons, O'Malley, O'Connor, & Monaghan, 2010). It allows commissioners to set priorities and address outcomes that user’s value, which rarely happens in speech and language therapy practice (Roulstone, Coad, Ayre, Hambly, & Lindsay, 2012). Service user’s experience of services can be explored to examine what worked best for them. They can propose Ideas for improving services and tackle difficult service issues (Commissioning Support Programme, 2011). Furthermore, service user’s health literacy skills (reading, numerics, cognitive and social skills) should be promoted in order to ensure access to health information (Hester & Stevens-Ratchford, 2009). This empowers service users to be active participants in their own health. There should be a strategic approach to participation, ensuring access to service users who are hard to reach and whose voices are seldom heard (Commissioning Support Programme, 2011).

To avoid merely consulting service users on their views, levels of participation will be outlined to reflect meaningful and active involvement, with increasing levels of reflection and action (Commissioning Support Programme, 2011):

- Informing is the initial step which involves providing information to children, parents and guardians about services available to them
- Consulting involves a more involved level of participation, obtaining service user's views on their experiences
- Involving is the next stage which consists of working in partnership with service users to ensure their needs are considered.
- Collaborating involves developing alternatives to current service provision and service user’s preference.
- Empowering involves the pinnacle of service user involvement—co-production of outcomes (Commissioning Support Programme, 2011). Service users are not merely consumers of services, rather partners in designing services. Speech and Language Therapists can participate in a collaborative approach, respecting children and families as effective partners in shaping speech and language services.

2.3 Service User involvement in the Education sector

Speech and language therapy literature has well established service user views and the lived experience of speech and language impairment (Lyons et al., 2010; McCormack, McAllister, McLeod, & Harrison, 2012; McCormack, McLeod, McAllister, & Harrison, 2010). The educational context differs. Flynn, Shevlin, & Lodge, (2012) and Flynn (2013) report that the voices of young people from marginalised groups are ignored and patronised in educational decision making. Education excludes young people with labels attached to them, particularly children and young people with emotional and behavioural needs. They are at greater risk than their peers of experiencing disaffection, failure in school and social exclusion (Brennan & Flynn, 2013; Weare, 2013).
It is ironic that schools marginalise children who shout the loudest (Tangen, 2009). However, listening to the voices of young people with emotional and behavioural needs is a useless endeavour unless these views are taken seriously, affecting real change in policy making and decision making (Symonds, 2008). Flynn, Shevlin, & Lodge, (2012: 29) reports “pupil voice cannot be realised as an authentic or consultative process unless it is met with some form of acknowledgement that can precipitate real change or transformative action.”

Crighton, Forsyth & Cameron (2008) advocate for creating quality communication environments at school by listening to what young people are saying. Speech and Language Therapists can consult all individuals around the child including teachers, parents and families to ensure that language and communication strategies are consistent across all environments (O'Connor, Mahony, Reilly, & Duggan, 2012). This approach will be adopted in this project. However, as Hutchinson & Clegg (2011) note, evidencing change in educational contexts is not well documented. Cremin, Mason & Busher (2011) report that schools are not well placed to engage pupil voice due to cultures of accountability that do not facilitate young people or adults to have a say in what happens in schools on a daily basis. Consequently, the facilitator will elaborate on power relations in school environments in section 2.6.3.
2.4 Collaborating Across Health and Education Sectors

Communication is an essential life skill, enabling independence, participation and responsibility (Marsh, Bertranou, Suominen, & Venkatachalam, 2010). Communication skills are necessary for academic achievement and mental health. High prevalence rates of speech, language, and communication needs are reported among children with emotional and behavioural disorders. Several longitudinal studies highlight the link between early speech and language impairment and long term psycho-social adjustment problems (Clegg, Hollis, Mawhood, & Rutter, 2005; Snowling, Bishop, Stothard, Chipchase, & Kaplan, 2006). Speech and language impairment affects children's success in verbally loaded interventions provided by mental health professionals (Pearce, Johnson, Manly, & Locke, 2013). Therefore, there is a call for reconceptualising speech and language therapy delivery across health and education sectors (Bercow, 2008; Law, McBean, & Rush, 2011; Law, Reilly, & Snow, 2013).

Research evidence in the U.K., highlights the importance of effective collaboration between Speech and Language Therapists and teachers in providing universal services to children with speech, language and communication needs. The ability to use language and communication skills effectively underpins the entire school curriculum.
Training the wider workforce is crucial, targeting the children’s communication environment as well as offering specific advice and support to the child (Gascoigne, 2012). Consequently, the interactive environment becomes the client as barriers to communication in the wider system are targeted in order to help the child communicate more effectively.

Interagency working is central to integrated children’s services. All professionals can plan common goals and engage in role release (Gascoigne, 2008). In the U.K., operational and strategic management has ensured the pooling of budgets across health and education, joint priority setting and locally based commissioning structures to ensure interagency working. Innovation flourishes, resulting in better outcomes for children with speech, language and communication needs. There is a lack of corporate governance and policy structures in the Irish context to promote interagency work, resulting in fragmentation and segmentation of services. Corporate Governance involves effective management systems and structures (Mental Health Commission, 2007).

Inter agency evidence in the U.K., supports the use of enhanced consultative approaches to support children’s learning.
However, the studies remain a collection of small scale local intervention studies rather than higher level strategic responses to joint commissioning of services, resulting in inconsistency and wide variability in outcomes for children, a sentiment echoed in the Bercow report (2008). Mecrow, Beckwith, & Klee (2010) and Hutchinson & Clegg (2011) demonstrate the effectiveness of enhanced consultative approaches to delivering speech and language therapy in schools. Direct and indirect language support delivered by teaching assistants was effective at improving children’s language. This approach involved considerable training of staff and parental support. However, the children were not randomly assigned to target and control conditions in the Mecrow, Beckwith, & Klee (2010) study. Children who did not receive therapy could also have made similar gains.

In contrast, Boyle, McCartney, O’Hare, & Forbes, (2009) and Dickson et al., (2009) used speech and language therapy assistants to deliver group therapy in schools, concluding with improved outcomes for children and highlighting innovative therapy methods. Boyle, McCartney, O’Hare, & Forbes, (2009) used a blinded randomised trial of innovative language therapy, using standardised assessments and manualised replicable therapy. The authors concluded that there was a need to investigate a model of integrated service delivery considering the persistent nature of children’s difficulties.
The essence of close collaboration is adopting relevant therapy goals for children. Nippold (2012) highlights the need for speech and language therapists to work closely with teachers as therapy goals need to be relevant to the curriculum. By third class, the language demands of classrooms are high. Children are expected to be competent in reading, reading comprehension, vocabulary, sentence formulation, narrative and discourse. Children with language challenges experience frustration as they struggle to cope with these demands. Therapy needs to be delivered in integrated collaborative ways. McCartney, Boyle, Ellis, Bannatyne, & Turnbull (2011) cautioned against the universal adoption of the consultancy model as education staff were not using language learning activities effectively. Consultancy approaches may not fit well in mainstream primary classrooms.

The consultancy model poses challenges to all disciplines, specifically in relation to different cultures, structures and processes used by Speech and Language Therapists and education staff. Moreover, the term “consultation” has been criticised for being over simplistic, resigning Speech and Language Therapists to advisory roles and not acknowledging the need for dynamic involvement in the educational context (RCSLT, 2009).
2.5 Systems Approach

Consultative approaches evolved into broader systemic approaches to delivering speech and language delivery. Establishing communication friendly environments is part of this overall move towards providing effective language learning environments for children. This approach requires an entire workforce to understand how to help children develop receptive and expressive language in classrooms. The interactive environment is the focus of change (Starling, Munro, Togher, & Arciuli, 2012). Changing the quality of teacher-child interaction and the physical environment of the classroom provide multiple opportunities to practice language and communication (Dockrell, Bakopoulou, Law, Spencer & Lindsay, 2012). Creating communication friendly classrooms mitigates the negative trajectory of untreated communication difficulties and the pervasive effects on children’s social, educational, emotional and behavioural development.

Starling, Munro, Togher, & Arciuli (2012) adopted a systems based approach by evaluating the effectiveness of secondary school teachers modifying their language to support students with language needs. Speech and Language Therapists trained teachers over ten weeks to modify their instructional language which resulted in improved written and oral language skills in students.
They advocated for whole populations support through interdisciplinary collaboration and integrated service delivery. The constellation of supports created a student centred language learning environment. Establishing trust was a key element to changing teacher practice.

Similarly, Leyden, Stackhouse, & Szczerbinski (2011) evaluated a whole school approach involving staff training in ten mainstream schools in the U.K. Head teachers and coordinators from five schools were interviewed regarding the benefits and challenges of implementing a whole school approach. School staff perceived benefits to the whole school language approach if there were appropriate resources, sufficient dedicated time and collaboration with key staff. A shared belief that speech, language and communication underpinned the curriculum, was critical to success. The backing of senior staff sustained the approach. These important conclusions will guide the facilitator in this project. Consequently, there is a need to consider the speech, language and communication needs of entire populations by adopting a public health approach, focusing on primary prevention (Law, Reilly, & Snow, 2013).

Gascoigne (2012) proposes a balanced system (Appendix 15) to support service redesign and commissioning, bringing together commissioning, provision, workforce training and leadership within a single model.
This model provides a useful framework for this project, in conjunction with the HSE model (Appendix 4) to ensure all children benefit from training the wider workforce (school staff, parents). Children with speech and language impairment will be identified in a more efficient, effective way and referred to targeted classroom groups supported by the facilitator. Step four of section 3.4.2 will elaborate more on this process. The balanced system supports the systems approach of intervention.

2.6 Barriers and opportunities in collaboration

2.6.1 Systemic Barriers

A systems approach will be used to examine the barriers to collaboration with schools and service users. Forbes & McCartney (2010) call for a careful rethinking of micro level professional knowledge and values, and meso level clinical practices (organisational level) with macro level governance and policy. The root of the current fragmentation of children's services is not outside but within the system, resulting in organisational conflicts and macro level segregation. Recent budgetary cuts and changes to working hours and conditions have impacted on teacher's access to mental health training. Similarly, budgetary cuts in mental health have impacted on access and consultation with schools.
Martin (2008) advocates for examining practitioner beliefs, attitudes and cultures across groups and their perspective on engagement. Jensen (2013) echoes this statement when he reports that organisations who fail to develop optimal interpersonal environments for clinicians will find that clinicians are less able to apply interpersonal skills needs to help children. Organisations need to engage with children and their families, forming and maintaining alliances and ensuring shared decision making with service users. It is important to also be cognisant of unpredictable group dynamics that are part of complex casework (Hood, 2014) as not every element in the system can be controlled and conceptualised. It is rather the combination of social factors- meso (organisational) and macro forces (policy) that exert a much greater force than individual micro factors. These factors combine to create a climate and culture within the school that ultimately affect children’s outcomes (Jensen, 2013).

### 2.6.2 Structural barriers

In addition to systems barriers, there are functional and structural barriers to collaboration. Schools are allocating services. All children attend school for a fixed number of years. In contrast, speech and language therapy is a commissioning service. The role of Speech and Language Therapists is to prioritise services, balancing children’s needs against overall resources available.
Therapists then target those who benefit most from the resource. Conflicts evolve with parents and school staff who believe that all children should access services (McCartney, Boyle, Ellis, Bannatyne, & Turnbull, 2011).

Models of collaboration are other sources of conflict as society views teachers and therapists as experts in their roles. Partnership across systems is a common rhetoric in health care (Hartley & Benington, 2011). However, joint goals across education and health are emerging but challenging due to social and structural barriers to their implementation. There are misunderstandings between agencies about good working relationships. Often, agencies are unaware of professional’s conditions of service. There are further challenges in relation to timing, location and curriculum structures which need clarification if therapists are to work alongside teachers (McCartney, Boyle, Ellis, Bannatyne, & Turnbull, 2011). Speech and Language Therapists often act similar to whole schools, relying on evidence based practice to make individual decisions about intervention. They adopt a developmental approach to language, matching intervention with the developmental stage of the child. Furthermore, teachers and Speech and Language Therapists use different terminology to describe language. All these challenges occur within a system which provides limited access for parents and children to jointly set goals with teachers (Forbes & McCartney, 2010). There are considerable power imbalances in complex adaptive systems.
2.6.3 Power and sustainability

Haigh (2008) asserts that evidence is required on how service user involvement impacts clinical outcomes. The collaboration of professional's technical knowledge and service user’s subjective knowledge can drive substantial improvements in service delivery (Bradshaw, 2008). However, the impact of service user's contributions are unquantified, and there is uncertainty amongst professionals about how to create a system that recognises service user involvement (Bradshaw, 2008). Healthcare and education involve complex, multifaceted systems involving organisational culture, political, economic and technical dimensions.

Embedding service user perspectives within these systems is a complex task involving a balance of power between professional’s expertise and user experience (Bradshaw, 2008). Power resides in the relationships and culture through which people communicate (Scharmer, 2009). Stickley (2006) argues that contemporary models of involvement in mental health perpetuate power positions. Overall, there is ambiguity about how to balance power between existing hierarchies and progress to achieving real sustainable change within complex adaptive systems. An awareness of power dynamics is needed to effect change as this is an obstacle to equitable involvement (Brosnan, 2012).
This project aims to provide children and parents with access and power to effect change in the educational system. Their views will be central to service delivery changes, outlined later in step three of section 3.4.2.

2.6.4 Solutions

It is useful to consider a framework to interagency collaboration involving service users. The Children’s Acts Advisory Board (CAAB, 2009) offered a framework for interagency work, advising that a justifiable rationale for inter agency cooperation needs to be outlined before work can begin. It is essential to have a leader to manage the interagency group in order to sustain the momentum to build partnerships and agree on shared vision. The space can address individual’s fears and concerns while openly acknowledging the barriers to interagency working. The interagency group fosters understanding between agencies using joint training or forums to share information about agencies. It is vital to develop common language between stakeholders by exploring differences in terminology. Joint performance indicators capture resources, activity, and benefits to collaboration. These recommendations will guide the facilitator at later stages of the project.
The rationale for this organisational development project is driven by lack of service user perspectives underpinning service links between child and adolescent mental health services and schools (O'Reilly et al., 2013). This new approach will require a paradigm shift for the facilitator who typically works on a multi-disciplinary team in a designated professional role. Changing mental models will evolve for service users and school staff. The move to negotiated partnerships will require adoption of a task culture rather than a role culture in order to plan and coordinate services at organisational levels. The facilitator will adopt distributed leadership throughout this organisational development project, to enable interagency learning.

2.7 Conclusion

The promotion of service user perspectives has been at the core of mental health legislation this decade. Nevertheless, there is pervasive cynicism and ambiguity in child and adolescent mental health and education as to how to incorporate service user's views in service delivery. Power and sustainability are significant obstacles in using service user voice to reshape services relevant to their unique needs. Fragmentation of services has evolved between health and education sectors as each sector scrambles to meet the needs of clients within resource confined organisations.
However, it is well established that children referred to child and adolescent mental health have multiple needs particularly educational needs, which require the cooperation of service users and multiple agencies (O'Reilly et al., 2013). Chapter three will proceed to outline the change process, to involve the wider system in support of children with speech, language and communication needs.

Chapter 3: Methodology

3.1 Introduction

This chapter will detail the cyclical nature of the organisational development project, incorporating service user’s perspectives and referencing the change management model adopted. The model used for this project was the HSE change model (2008b). This chapter will elaborate on the change process and the reasons for adopting the HSE change model. The project will be discussed using the different phases of the HSE model-initiation, planning implementation and mainstreaming. The conclusion will capture the key points which evolved from the change process.
3.2 Rationale for HSE Change Model

The HSE model of change (HSE, 2008b) is an effective model for the proposed change as change is a continuous process (Appendix 4). The initiation, planning, implementation and mainstreaming stages outline what is required within each stage, while mutually influencing other stages. The HSE model is particularly relevant to the whole systems approach adopted in this project. It provides an effective way of examining change across the system, describing the complex interdependency of action and reflection in order to improve services. A linear model of change management would fail to capture the cultural and relationship aspects of change, involving all stakeholders in the drive towards change and innovation. The HSE model emphasises long term sustainable change, with the responsibility for change targeted at all levels of the system (Iles & Cranfield, 2004), driven by distributed leadership. It is envisioned that a flatter hierarchy will evolve as school staff and facilitator meet to discuss proposed changes and initiate innovative ways of working. The model is values driven which is critical to building a coalition of support across sectors. The framework can be used to highlight that the system is operating on development mode, continuously adapting and improving itself (Iles & Cranfield, 2004). Prepared agendas and proposals will continually have to be altered to adapt to new information received from stakeholders. A paradigm shift can only occur when the true picture evolves, with all elements in the system interacting in the context of dynamic change. Power, political and cultural paradigms will be considered in this project as significant handing over of power will need to take place if the true partnership can evolve with children, parents and the education sector.
3.3 Change Model

3.3.1 Initiation

Step 1 Preparing to lead the change

The initiation stage lays the foundations for the organisational development process. The challenge for leadership is to respond to changing contexts proactively and understand the key drivers and resistors to change across organisations (McAuliffe & Van Vaerenbergh, 2006). Firstly, a Force Field diagram was used to illustrate the drivers and resistors to change and assess people’s willingness to change (Figure 1).

Figure 1: Force Field Analysis

<table>
<thead>
<tr>
<th>Forces FOR Change</th>
<th>Proposed Change</th>
<th>Forces AGAINST Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy environment</td>
<td>Scope &amp; scale of change</td>
<td></td>
</tr>
<tr>
<td>Senior management</td>
<td>Segregation of sectors</td>
<td></td>
</tr>
<tr>
<td>Author interest &amp; training</td>
<td>Systemic barriers</td>
<td></td>
</tr>
<tr>
<td>Best practice guidelines</td>
<td>Resistance to change</td>
<td></td>
</tr>
<tr>
<td>Whole school evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key drivers include HSE policy and Vision for Change framework that emphasise the need to consider service user perspectives in planning and delivery services. Policy shifts in disability offer opportunities for role redesign that cut across professional and sector boundaries (McAllister, Wylie, Davidson, & Marshall, 2013). Internally, senior management facilitated a change in service provision to schools in order to increase access and equity for service users. The whole school evaluation occurred at a critical moment in the change process, involving the inspection of the school structure and systems by two senior members of the Department of Education (section 5.2 of chapter five). Internal resistors to the proposed change include the challenge of communicating the scope and scale of the proposed changes across agencies. The literature review highlighted segregation of health and education cultures which are significant barriers to change. The facilitator used this Force Field Analysis diagram to communicate the need for change at weekly meetings with school staff. The diagram facilitated visualisation of wider systemic elements, which as outlined in the literature review, have a larger effect than micro factors alone. While school staff acknowledged that the universal support of children’s communication skills was a valuable shared goal, they were apprehensive about their role in the change process. The facilitator decided to form a coalition of support by consulting multiple stakeholders to assist in driving the momentum for change. NICE (2007) recommend talking to key individuals and stakeholders with regular meetings to obtain specific details of the problems you are likely to face. Therefore, a stakeholder analysis was used to identify relevant and powerful parties to support the change. This is a useful tool to guide a leader to adapt the change process in response to stakeholder’s views and gauge overall receptivity (Table 1).
Table 1: Stakeholder Analysis

<table>
<thead>
<tr>
<th>High Importance/Low influence</th>
<th>High Importance/High Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users</td>
<td>Clinic Senior management</td>
</tr>
<tr>
<td>Department colleagues</td>
<td>School Principal</td>
</tr>
<tr>
<td>Special Needs Assistants</td>
<td>Teachers</td>
</tr>
<tr>
<td></td>
<td>School board of directors</td>
</tr>
<tr>
<td></td>
<td>Consultant Psychiatrists</td>
</tr>
<tr>
<td>Low Importance/Low influence</td>
<td>Low Importance/High Influence</td>
</tr>
<tr>
<td>Staff not involved with client group</td>
<td>Medical board</td>
</tr>
<tr>
<td></td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

The stakeholder analysis facilitated targeted communication towards key stakeholders throughout the project. The facilitator established an ally with one Consultant Child and Adolescent Psychiatrist, who supported the process and requested feedback on the project at a later stage. Weekly meetings with school staff facilitated communication of the roles of facilitator and school staff in leading the change. Shared responsibility for change was a central theme in weekly meetings. This new structure facilitated collaborative team working. The meetings offered opportunities to address resistance as it emerged and to pace the change according to staff readiness. The staff and facilitator considered significant gaps in resources and communication systems within the school.
The 7S model (Peters & Waterman, 1984), illustrated in Appendix 5, was used in order to view the systemic aspects of change. This tool was valuable in highlighting the strengths and weaknesses of the school system and the links between each s-shared values, systems, structure, strategy, skills, staff, and leadership style. Iles & Cranfield (2004) advocate using the 7S model to allow holistic thinking about the resources and competencies within a team. Better children’s communication outcomes are beyond the remit of one profession, team or agency. This model provided a framework for capacity building within the school and joint planning of new processes, important components of the evaluation stage.

3.4.2 Planning

Step 2: Building commitment

During the planning stages, a five point action plan was envisioned by consulting children, parents and school staff on their perspectives of speech and language therapy in the school. Action research (Table 2), underpinning organisational development, was selected as an appropriate methodology for this project as it is grounded in real life (Coghlan & Shani, 2013). Integration of action and knowledge cycles provide a context for reflective inquiry (Coghlan & Brannick, 2009). This methodology supports the collaborative learning process and is participatory in nature (Lyons, O’Malley, O’Connor & Monaghan, 2010).
The action component guides the reflective process which ultimately influences learning and change (Dilworth & Boshyk, 2010).

**Table 2: Action research process**

<table>
<thead>
<tr>
<th>Reflect and plan</th>
<th>Research Ethics approval, build coalition of support by communicating with stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act and collect data</td>
<td>Participants invited to focus groups</td>
</tr>
<tr>
<td>Reflect</td>
<td>Focus group data analysed to inform action plan</td>
</tr>
<tr>
<td>Plan</td>
<td>Action plan created in consultation with staff</td>
</tr>
<tr>
<td>Act</td>
<td>Visual schedules implemented, classroom vocabulary groups, parent training, weekly teacher meetings</td>
</tr>
<tr>
<td>Collect data: evaluation</td>
<td>Multiple stakeholder questionnaires distributed and analysed</td>
</tr>
<tr>
<td>Reflect</td>
<td>Evaluation informs change process</td>
</tr>
<tr>
<td>Plan</td>
<td>Plans for next intervention steps</td>
</tr>
</tbody>
</table>
Data collection

Firstly, ethics approval was secured from the mental health clinic’s Research Ethics Committee. Focus groups collected service user experience, which are a powerful method of evaluating current practice and testing new ideas (NICE, 2007). This method enables a representative group of people to discuss ideas and facilitates engagement in the change process, which is critical to mainstream and sustain change. Individuals can bring items for discussion which are important to them, giving a more accurate reflection of their views (Bryman & Bell, 2007). Purposive sampling was undertaken to select children, parents and staff who were likely to contribute their opinions on speech and language therapy. One class of five children, with the mean age of ten years, their parents, three teachers and one Special Needs Assistant were invited to participate in the project. The children had attended previous speech and language groups and were linked in with local mental health teams. Information leaflet and consent forms were forwarded to the participants (Appendices 1-3).

The facilitator conducted four focus groups, two for parents, one for school staff and one for children. The facilitator as the sole interviewer and Speech and Language Therapist within the school, reflects a bias that impacts on disclosure.
Nevertheless, parents were reflecting on the speech and language system which involved several different therapists over several years. Four parents took part in two one hour fifteen minute focus groups. Topic guides are included in Appendices 6-8. One sixty minute focus group was carried out with five children. The children’s two teachers, one resource teacher, and one Special Needs Assistant also attended one sixty minute focus group. The focus group interviews were video recorded, transcribed and analysed using the principles of thematic content analysis to highlight key patterns and themes.

Data Analysis

Thirteen participants took part in focus groups. The facilitator then analysed four and a half hours of videotaped interviews. All data was transcribed and then subjected to a process of inductive analysis. Inductive analysis is a form of thematic analysis which aims to code data in the absence of a pre-existing framework. The data collected form the basis from which inferences are drawn (Bryman & Bell, 2011). Inductive analysis is based on Burnard’s (1991) model of thematic content analysis. Content analysis is an approach to the analysis of documents and seeks to quantify content according to categories in a systematic way (Bryman & Bell, 2011).
The process of inductive analysis was undertaken by repeated readings of the data, followed by line-by-line analysis of transcribed focus groups, in order to identify units of meaning. These units were then given descriptive codes and compared with each other. The data reached a conceptual saturation when no new codes emerged. The facilitator then summarised all coded data into descriptive themes. These opinions formed the basis of the action plan outlined in step four.

**Step 3: Determining the detail of the change**

This involved analysing the present situation from the perspective of children, parents and school staff. The themes that emerged from focus groups included:

1. **Raising Awareness of Speech, Language and Communication Needs**

Parents reported lack of understanding of speech, language and communication despite being involved with speech and language therapy for several years.

P4 “Well I really don’t know an awful lot about it. I know that R sees you once a week. I know that his vocabulary is improving. I know that he’s doing a bit better but other than that, I really don’t know as regards the language part of it.”
Other parents reported a lack of general awareness amongst friends and relatives which put pressure on them to constantly explain their child’s difficulties.

P2 “People kept asking me why is he going to speech and language? Sure he can speak like. They literally think that speech and language is teaching them how to talk, how to pronounce, like elocution lessons or something.”

Children did not report difficulties with speech, language and communication. They did, however, note that people in their environment can help or hinder their communication skills.

M1 “Is there anything adults can do?”
C2 “Suggest things you are trying to say.”
M1 “So basically if you get stuck, you’d like people to help you out?”
C1 “I’d love it to be quieter, so you can get your work right and learn more.”

Teachers considered speech and language external to the school system, providing materials to resource teachers for use with individual children.

T1 “My past experience has been outside the school that they would go externally. I did work with a child last year, his mother was given all the materials that the Speech and Language Therapist was working on that was supportive to the class”
T4 “I’ve never had a time where now it’s time for speech and language.”
2. Strategies

Parents tuned into strategies that would benefit their children at school.

P3 “Things that are couched in more fun are more effective.

If they don’t feel like its work, you’ll get more progress than if they feel they are regurgitating something.”

The children were suggested the use of games in the classroom to support their communication skills. Fun was high on their agenda.

C5 “Pass the bomb, is just like bomb except you have to make up tons of words.”

M1 “What’s so good about that anyway?”

C3 “Because it helps you with your pronunciation.”

Teachers noted that the use of games in the classroom was problematic.

T3 “I have to say in my classroom that game doesn’t work. Some of those games because T is so competitive and that causes a lot of his kick offs so he works best when he is working independently or with a Special Needs Assistant but he can’t do group work.”

Visual strategies were proposed as a way of addressing each child’s different learning styles and also as a method of facilitating children’s comprehension. There was disagreement as to whether visual strategies would increase dependence in their children.
P2 “S is ten now. He needs to start working without visuals. He needs to know he has to start working without playtime. He’s a little bit old for that because when they go to secondary, there is going to be none of this carryon.”

Parent three disagreed and discussed the benefits of using visual organisers as children progressed through the school system.

3. Parental Engagement & Communication

Parents were interested in being involved in their children’s speech and language therapy. They sought written communication from the facilitator in order to effect change in their children’s communication.

P3 “We are with them the other twenty four so we could be your biggest resource if used properly”.

P4 “The diary and every week there is a note sent home saying what you have done and that is absolutely brilliant. Prior to that, I had no communication with the school whatsoever.”

Parents sought positive communication with the school.

P3 “There needs to be something where we communicate, not crisis communication, a chance for there to be positive communication as well.”
Parents were critical of the lack of communication between mental health clinics and the school as they viewed this communication as essential for their children’s progress.

4. Preferred outcomes

Parents would like their children to be independent and make friends. They worried about their children’s futures in terms of communicating in the workplace, maintaining intimate relationships and getting involved in criminal activities. Following the focus groups, a five point action plan was established in consultation with school staff on how to create a communication friendly school environment using a whole school language approach. Section 2.5 of the literature review already outlined the importance of adopting public health service delivery model. The details of the action plan are as follows:

**Step 4: Developing the implementation plan**

Firstly, the facilitator proposed a shared belief that language and communication underpin the curriculum.
Gill's (2011) asserts that in order to show others the way, a shared vision of the future is proposed based on shared values. Weekly communication meetings were set up with school staff to instil this vision. The facilitator and school staff established shared values, using the 7S model (Appendix 5) as a framework. They consist of integrity, willingness to openly discuss conflicts and challenge each other’s thinking. Secondly, wider systemic issues would need to be addressed according to the 7s model. The entire workforce would have to be galvanised in order to support children’s needs. The structure, systems and skills of the workforce would have to change in order to support the change strategy. Therefore, the facilitator laid the foundation at weekly meetings by reiterating shared understanding, shared vision of desired outcomes and possible impact measures. The facilitator discussed roles, responsibilities and accountabilities, including conditions of service that differed across health and education sectors. The facilitator outlined her role in the project, discussed in section 1.5.

Frequent communication with school staff uncovered significant historical resentment. School staff expressed anger at outside agencies providing little support to the school and working against the aims of the school. Teachers criticised the lack of speech and language resource (two days per week). Teachers reported that speech and language therapy was episodic and not in line with the long term needs of children. The facilitator envisioned this process as part of the natural life cycle of a team (Tuckman, 1965) with the needs of individuals dominating the process initially rather than focusing on tasks.
The school staff were at the forming and storming stages. These conflicts offered opportunities to work in innovative ways. The facilitator negotiated provision of universal staff and parent training and targeted intervention to children using a whole school language approach. The facilitator proposed the following action plan to achieve this aim:

1. Inviting parents and school staff to training workshops on how to support children’s vocabulary skills

2. Weekly coaching in order to encourage teacher's use of word maps (visual strategy)

3. Thirty five children (aged eight to twelve years) were selected to attend nine weekly thirty minute vocabulary groups in their classroom. The facilitator targeted vocabulary as it underpins literacy and social interaction using the Vocabulary Enrichment Intervention Programme (Joffe, Dean, Madhani, Kotta, & Parker, 2009). Ten children were not invited to groups due to conduct and school attendance issues.

4. Facilitating weekly meetings in order to create an urgency for change and sustain the momentum for change (Kotter, 2008)

5. Reviewing and renegotiating the action plan

There was immediate resistance to this action plan as teachers expressed that they were already overwhelmed with competing initiatives.
The facilitator persisted in reiterating the importance of providing children with opportunities throughout the day to practice their communication skills. This included demonstrating how to support the children’s physical environment with visual cues, and small group work to provide structured opportunities for quality interactions between children and school staff. The facilitator proposed to commence the implementation phase by introducing visual strategies in classrooms. The rationale for the strategy was outlined (facilitate children’s vocabulary skills) and reiterated throughout the implementation stage.

### 3.4.3 Implementation

**Step 5 implementing the change**

The implementation phase of the change initiative was further negotiated during weekly meetings. The facilitator challenged resistance by outlining clear expectations with joint goal setting. Central to the implementation plan was supporting children and their parents with information and skills to enable them to be pro-active in making their own choices. Coaching and training supported the wider workforce to improve children’s vocabulary skills. The Vocabulary Enrichment Intervention Programme (Joffe, Dean, Madhani, Kotta, & Parker, 2009) facilitates understanding and expression of children’s words through word associations, categorisation, mind mapping and word building.
Explicit communication of the aims and learning objectives of the programme focused staff on the importance of supporting vocabulary development in children. Additionally, parents attended a workshop to discuss practical strategies to support their children’s vocabulary development. Low numbers (five out of thirty five) attended the workshop reflecting perhaps apathy and lack of engagement.

Consequently, the facilitator invited parents to a coffee morning, which is a less threatening environment, to promote engagement in the change effort. Ten more parents attended the event, explaining practical concerns for previous non attendance including lack of transport and inflexible working hours. Parental engagement was put on the agenda at weekly staff meetings, an important need for parents and lacking in the school. Initially, there was significant reluctance to engage with parents. The facilitator conceptualised this reluctance as resistance to change. Teachers were uncomfortable when hearing parent’s views and reverted to professional jargon when discussing parent’s needs.

Teachers voiced their concerns about attending training workshops. They reported that they did not have time to attend workshops or plan - further structural challenges in the 7S model of systems (Appendix 5). The organisation development approach to resistance is to treat resistance with respect by considering it a healthy, self-regulating process (McAuliffe & Van Vaerenbergh, 2006).
Kotter & Schlesinger (1979) propose to build support through facilitation by exploring areas of resistance, persuading for commitment to change and facilitating attitude and behaviour change. The facilitator advocated for the views of children and parents as an initial step towards acknowledging their role in the change process. Further structural changes would be necessary in order to sustain this change. The school principal agreed with the setting up of a parent panel, once monthly in the school from April 2014. A newsletter would be sent to parents who could not attend. The panel will offer parents opportunities to voice their opinions on how the school system operates and mainstream further changes within the school. Unfortunately, there was not enough time to evaluate the parent panel during one action research cycle. This action will be carried out at a future date.

3.4.4 Mainstreaming

Step 6 making it “the way we do our business”

The mainstreaming phase of the project embeds the change initiative in the school. Throughout the change initiative, children and parents co-produce outcomes rather than simply consume services (Commissioning Support Programme, 2011). Co-production of outcomes offers service users the opportunity to propose solutions to their own care. The children offered innovative solutions by suggesting activities during focus groups. Parents suggested visual schedules in classrooms to facilitate vocabulary skills.
Teachers suggested adopting more oral language lessons rather than exclusively focusing on literacy. In effect, the wider workforce provided universal and targeted speech and language therapy to the children. The staff celebrated these important milestones as small successes. Classes celebrated with prizes for the “most visual” classroom. This change process ensured that the language targets integrated into the whole school plan, in order to sustain this new way of working.

**Step 7 Evaluating and learning**

Essential sustainability factors including flexibility and openness to change, ensure that the school remains relevant and responsive to the views of children and parents (HSE, 2008b). The facilitator reviewed and refined activities according to multiple stakeholder feedback (section 4.3.1 of the evaluation stage). The facilitator observed children’s vocabulary changes over the nine week period using qualitative analysis of word maps. Parents were kept informed of the classroom groups with weekly letters (Appendix 13). Follow up phone calls provided extra support to parents who had literacy difficulties. The facilitator continued to discuss structure, system and staff training issues at weekly meetings to ensure all parts of the system were working to support children’s vocabulary skills. A paradigm shift evolved as factors within the whole system (using 7S and HSE models) were considered in contrast to historical mechanisms that focus on specialist inputs from speech and language therapy.
This balanced solution (Appendix 16) requires a whole system to respond to deliver outcomes.

3.5 Conclusion

The HSE model of change was an effective reference point for the change initiative by setting out dynamic process of steps to planning, managing and implementing change. The facilitator engaged in consistent and frequent communication with stakeholders from the outset in order to build a solid foundation, a coalition of support and ensure readiness for the change process (HSE, 2008b). Children, parents and school staff were central to the action plan, directly feeding into the plan with their views. The facilitator emphasised shared responsibility and vision for change in order to engage and empower the entire workforce toward better outcomes for children and their families. Multiple skills and perspectives embraced the change that will be evaluated in chapter four. Furthermore, chapter four will evaluate SMART aim and objectives outlined in section 1.2, research methods and key findings.
Chapter 4 Evaluation

4.1 Introduction

Evaluation of this organisation development project is critical to sustaining changes implemented in the school environment and the wider context. Qualitative and quantitative evaluation captured the experiences of multiple stakeholders. Gascoigne (2012) reports that integrating speech and language therapy, specialist teachers and assistants is an efficient, effective approach which redistributes services to follow evidenced need. Similarly, this project will demonstrate improved efficiency in a system where school staff, facilitator and parents are working together to share responsibility for improved vocabulary outcomes in children. Firstly, the facilitator will discuss the rationale for evaluation, followed by an evaluation model to provide a framework to discuss the evaluation process. Reference will be made to SMART aim and objectives, research methods and research results.
4.2 Rationale for evaluation

In relation to evaluation trends, a paradigm shift occurred with less focus on behavioural outcomes and more demands for value for money, accountability, process, stakeholder input and quality (McNamara, Joyce, & O’Hara, 2010). An emerging trend in speech and language therapy is towards economic evaluations. Cost effectiveness studies identify which interventions generate better outcomes for children (Beecham, Law, Zeng, & Lindsay, 2012). Marsh, Bertranou, Suominen & Venkatachalam (2010) demonstrated that speech and language services in the National Health Services (NHS), U.K., provided evidence for return on investment by evaluating national unit costs. While the cost of intervention is an important criterion for selecting intervention, it is one of many necessary elements when deciding to spend resources wisely (Beecham, Law, Zeng, & Lindsay, 2012).

This project will not evaluate unit costs of intervention due to resource and time constraints. The aim of this evaluation is to demonstrate improved efficiency of a scarce speech and language resource from the perspective of multiple stakeholders, a valuable goal considering the current economic climate. This warrants multi layered evaluation incorporating different needs from different people at different times (Øvretveit & Gustafson, 2003).
Moreover, this project will require cyclical sequential phases in the future as practical knowledge is always incomplete and can only be explored by considering what is needed in specific situations at specific points in time (Coghlan & Shani, 2013). Coghlan and Brannick (2009) define practical knowing as doing appropriate things competently.

4.3 Evaluation models

An evaluation model was carefully chosen to reflect multiple perspectives considering the significance of the evaluation process to the overall success of this project. Kirkpatrick’s model (Kirkpatrick & Kirkpatrick, 2006) is an outcome based approach, useful when evaluating training and development. This approach uses a four step linear model to determine learning before and after training. However, a linear approach to learning would be counterproductive to this change effort. A process evaluation model is appropriate for assessing complex adaptive systems. Therefore, the facilitator selected Jacob’s model (2000) as it allows evaluation of qualitative information from a variety of stakeholders.
This model presents a framework for educational innovation and change, which is appropriate to the context of this project. Jacob’s model (2000) outlines a ten stage model which emphasises collaboration, negotiation and consultation around the context and policy of intervention (McNamara, Joyce, & O’Hara, 2010). Conceptualising this project in the wider context is vital to sustaining this change effort.

Macro level factors— the wider educational, health context and Government policies will have an effect on the success of this project as well as the wider social, economic and the broader political climate. The facilitator discussed these macro level factors in the literature review in section 2.6.1 and the Force Field Analysis, in section 3.3.1. Jacob’s model (2000) offers flexibility in moving between stages to allow holistic overview of the entire system, the constant theme in this systemic change effort. This model will now be outlined to reflect the interest of multiple stakeholders.
4.3.1 *Jacob's evaluation model*

*Stage 1: Locate the innovation within the context and policy framework of its operation* (section 1.3).

*Stage 2: Determine the goals of the evaluation.* This evaluation will measure how well this project performs in line with the SMART objectives, outlined in section 1.2.1. Objective one involves measuring five children’s language and communication skills using standardised assessments in November 2011. The facilitator screened the children’s communication skills over two sessions at school using the Clinical Evaluation of Language Fundamentals- 4UK (Semel, Wiig, & Secord, 2003) and the Children’s Communication Checklist (Bishop, 2003). All five children presented with receptive- expressive language impairment (difficulty understanding others and expressing themselves), specifically vocabulary delay. Three children presented with social communication difficulties.

Objective two involves evaluating the views of five children, their parents and teachers in focus groups on how best to meet speech, language and communication needs at school. The data analysis section of section 3.4.2 evaluated this objective which led to the implementation of a five point action plan.
Objective three involves implementing changes to service delivery according to children, parents and school staff’s needs. The facilitator and school staff implemented an action plan and created a communication friendly classroom environment for children. This supportive environment evolved by providing universal support to parent and school staff with training and coaching, weekly meetings and targeted support to children with classroom vocabulary groups. This approach is a public health model of service delivery, advocated by Law, Reilly, & Snow (2013), an efficient way of using a scarce resource to target children with speech, language and communication needs. Objective four involves evaluating the effectiveness of service delivery changes by consulting multiple stakeholders. Stage nine of this model will evaluate objectives three and four.

Stage 3: Identify the principal stakeholders from all constituencies. The principal stakeholders in this project are the children, their parents/guardians, teachers and Special Needs Assistants. Other stakeholders, identified in the stakeholder analysis (section 3.3.1) include clinic and school management. Both bottom-up and top-down approaches will be used to evaluate this change initiative.

Stage 4: Identify the aspects of the innovation to be evaluated

Children’s aspects:

The change in vocabulary skills after attending the Vocabulary Enrichment Programme (Joffe, Dean, Madhani, Kotta, & Parker, 2009)

Change in class environment
Perception of Speech and Language Therapy

*Parent aspects:*
Change in their children’s vocabulary

Perception of speech and language delivery at school

Resources required to support speech and language therapy delivery in class

Views on speech and language training workshop

*Teacher/ Special Needs Assistant Aspects:*
Change in children’s vocabulary after attending vocabulary programme

Support/resources required to deliver speech and language therapy in school

*School Management and Clinic Management:*
Perceptions on how to support universal and targeted speech and language therapy in school

**Stage 5: Determine the criteria for evaluating aspects of the innovation:**

Qualitative and qualitative analyses will highlight the effectiveness of offering universal and targeted support to children with vocabulary needs according to stakeholder views. The 7S model (Appendix 6) explores systemic barriers which ultimately affects the sustainability of the project. Feedback from school and clinic management will highlight the need to drive further improvements in integrated care for children with communication and mental health challenges
Stage 6: Decide on the best sources of information - Stakeholders identified in stage three.

Stage 7: Decide on the evaluation methods to be used:

Jacob (2000) recommends using contrasting methods including both quantitative and qualitative information to meet the needs of various audiences. Qualitative and quantitative data collection using questionnaires, reflect the perspectives of multiple stakeholders. The advantages of using questionnaires are access to a wider audience, and low cost, important considerations as stakeholders are scattered across wide geographical areas. Costs of time and travel impacted on the numbers of parents available to attend pre-intervention focus groups and training workshops. Large quantities of questionnaires can be sent out which will assess the impact of interventions at a population level. There is an absence of interviewer effects (Bryman & Bell, 2007), including interviewer bias that affects interviewee disclosure. Disadvantages of questionnaires include the inability to probe or prompt and the impact of low literacy on completing questionnaires. Qualitative information will be evaluated using the children’s word maps to analyse improvement over the course of intervention. Additionally, the questionnaires will be analysed to reflect themes. Quantitative information will include the numbers of completed questionnaires from various stakeholders, response rates and percentage of stakeholders who agree/disagree with questionnaire statements (Appendix 14).
Stage 8: Collect data from sources:

The aim of distributing questionnaires to multiple stakeholders was to gather views of all key players who can effect change in children’s vocabulary skills. The facilitator distributed questionnaires in March 2014. The numbers distributed, response rates and quantitative analysis of responses are shown in Appendix 14.

Stage 9: Analyse and interpret data:

The low response rates from parents, school staff and clinic management highlights the need for further sustained efforts to be directed towards engagement in the school and across sectors. The 7S model (Appendix 6) will be used to continue building staff skills and facilitating interconnectedness with shared values, common language, procedures and processes. The evaluation occurred at the end of one cycle of the action research process. Further cycles are required to sustain project outcomes over time. Further evaluation will facilitate reflection, inquiry and generative learning which will inform future planning (Coghlan & Shani, 2013).
Results

Quantitative outcomes

The quantitative outcomes of this project to date are:

- The parent workshop and follow up coffee morning
- The establishment of a service user panel in the school
- Nine weekly vocabulary group sessions targeting thirty five children in the school and staff support for implementation
- Liaison between the school and local mental health clinics by providing regular updates to clinic management, and two mental health teams
- Weekly meetings with school staff

These outcomes represent significant achievements by providing the foundation for further integration and coordination between education and health agencies. The 7s model (Appendix 5) and HSE model (Appendix 4) facilitated holistic overview of the entire educational system. Further systemic and structural changes are necessary to order to promote parent and clinic engagement in the school. As outlined in section 1.3, there is a need to communicate with mental health, family support agencies and child protection services considering the prevalence of families attending local child and adolescent mental health services and the numbers of children in care. Children with communication and mental health challenges are a heterogeneous group with complex needs (O'Reilly et al., 2013).
Qualitative outcomes

Multiple stakeholders identified benefits and challenges to speech and language and school collaboration. The facilitator was inspired to keep moving forward driving further changes in the system. Some comments are included below:

- “It was good and fun having a speech therapist in the class”- child
- “I think having the specialist knowledge and skills of a speech and language therapist can benefit the children’s vocabulary skills and support the class teacher”- Special Needs Assistant
- “During lessons in class, some children have brought up discussions in a positive way. As the months went on, I felt they weren’t as shy and got involved more”- Teacher
- “More collaboration with the teacher prior to the sessions would be very beneficial. Expectations of behaviour management also crucial”- Teacher
- “It can be frustrating (working with a Speech and Language Therapist) as I’d like a clear plan with outcomes before the term so I can include it in my plans”- Teacher
- “Benefits noted in overall parenting and development of children by enhancing parents understanding of the centrality of language to development, socialisation and emotional processing”- Child and Adolescent Psychiatrist
While there was a variety of important quantitative and qualitative outcomes in this project, it is premature to ascertain the overall success of this project as further cycles of reflection and action are required to embed this process in the school system. Nevertheless, significant improvements were noted and celebrated by the facilitator and school staff. Success motivated school staff and facilitator to continue to implement further cycles of action and reflection using the HSE model as a framework for change.

Stage 10: Disseminate the evaluation findings.

The facilitator distributed a summary report to the school management board and clinic management (Appendix 12). Additionally, the facilitator arranged meetings with two mental health teams and speech and language therapy managers. The discussions advocated for parents and school staff’s need for better communication between the clinic and the school. The facilitator emphasised the organisational impact of universal and targeted service delivery in the school setting. This information was received well by mental health teams who acknowledged the difficulties inherent in interagency communication. The facilitator adopted an advocator role, ensuring that mental health professionals were aware of parents and school staff’s need for frequent communication about a child’s mental health needs.
4.4 Conclusion

Feedback from multiple stakeholders provided positive affirmation to keep moving forward implementing further changes to contribute to improved outcomes for children. Parents and school staff noted improvements in children's vocabulary and interaction skills. Weekly school meetings improved communication within the school. Discussion with mental health professionals and school staff emphasised the need for better communication between health and education agencies. Further cycles in the action research process are required to embed these changes across two systems. A synergy created in the school system, based on mutual trust, support and collaboration will facilitate staff engagement in future cycles of this action reflection process. This project provided a platform for engaging in interagency work, creating a coordinated service which addressed what children, parents and school staff need from a speech and language therapy service. Chapter five will proceed to discuss the extent of the organisational impact, strengths and challenges inherent in the project and implications of this project for other settings.
Chapter 5 Discussion

5.1 Introduction

This final chapter will identify the impact of change including strengths and limitations of this organisational development project. The literature review identified barriers and opportunities of service user involvement and collaboration across sectors including systemic and structural barriers, power and sustainability issues. The discussion chapter will elaborate on these points, linking to implications arising from the process. This project attempts to leverage change in a special school with effects on the wider social context. The facilitator will now consider the impact of behavioural, structural and personal changes in the school.

5.2 Organisation impact

Behavioural:

Weekly meetings facilitated exploration of conflicting goals between teachers and facilitator. This forum provided a space for critical thinking to explore the connection between children’s communication and behaviour difficulties.
Teachers acknowledged that children’s behaviour problems escalated due to limited vocabulary and interaction skills. Teachers reflected on the current use of restraint as a behaviour management technique and concluded that it is neither appropriate, evidence-based nor safe, putting everyone in the school, in crisis mode and exposing all to further harm. The facilitator experienced considerable moral dilemmas in addressing this issue with school staff (Reflective diary p.7). School staff and facilitator discussed alternative methods to behaviour management including using non-verbal communication to calm children, allowing children time and space to regulate their emotions. The facilitator recommended school consultation with multiple agencies across mental health and education to sustain this approach.

School staff noted an improvement in children’s communication skills in class. They reported an increase in children’s confidence and assertiveness to ask for help when they had concerns or general anxieties. Staff reported an increase in their own confidence on how to help children with speech, language and communication needs. Children’s language skills improved in group situations according to school staff. The majority of staff valued the groups over individual work as the children engaged more in the tasks. However, the group situation had to be managed with clear structure and routine in order to ensure listening, concentration and behaviour issues did not detract from group objectives. The multifaceted needs of children with communication and emotional challenges required close collaboration between staff and facilitator, working towards shared goals.
Teachers integrated word maps into the curriculum, that benefitted visual learners. Customised learning involving different forms of instructions and visual aids produce better learning (Rohrer & Pashler, 2012). A whole school approach integrated language and communication with the curriculum that was relevant and meaningful to school life. The teachers no longer view speech and language as external to the curriculum. This coordinated approach lays the foundation for further intervention.

Parents reported that they were pleased with parent meetings and workshops which kept them informed throughout the process. Parents noticed changes in their children’s behaviour and expression. They requested more information on using visual strategies to help their children’s communication skills at home. Parents benefitted from hearing another parent’s solutions during focus groups. However, more intervention needs to target system engagement so all individuals can take ownership of the project and adapt the project according to their own situation. Teachers acknowledged parents need to be more involved in service planning and evaluation.
Structural:

Teachers called for more structure in facilitating children’s communication skills in the classroom. They were critical of changes to timetabling groups that impacted on the children’s routine. Interagency work is challenging in this context as the facilitator and teachers have different schedules, duties and work conditions which need to be constantly communicated to order to reduce frustration for everyone. The facilitator negotiated ownership of the speech and language resource with staff as the wider workforce have the power to effect changes in children’s communication skills. Some individuals continued to adopt a role culture, waiting for the facilitator to direct change rather than implementing strategies.

Other outstanding structural issues include parent’s limited access to the school. The facilitator negotiated the setting up of service user panel group in April 2014 with the school principal. It is important to provide a social network for parents as they reported feeling isolated and burdened by their child’s behaviour difficulties during focus groups.
Cultural:

The organisational development project involved a considerable transformative experience for the facilitator, school staff, parents and children. Mental models are defined by Senge (2010) as how we make sense of the world and how we take action. Throughout the project, the facilitator attempted to challenge mental models explicit in order to allow collaboration throughout the system. The 7S model (Appendix 5) provided a framework for this by drawing reference to belief systems in the school, skills and staffing issues. The facilitator networked in the school and beyond, connecting people to talk openly about their issues and challenge each other’s thinking. The facilitator aspired towards a learning organisation based on shared vision, values and challenging mental models (Senge, 2010). School staff initially adopted a defensive stance that contributed to conflict (Reflective diary p. 7). Weekly meetings created space for reflection and learning that challenged how thinking and unilateral decision making contributes to conflict.

Personal:

Throughout the process, there was an atmosphere of vulnerability as the facilitator exposed self limitations in thinking to parents and school staff.
The speech and language therapy service was open for scrutiny. The facilitator required courage to face criticism as a member of a different agency who did not have a good reputation for communicating outside the confines of their organisation. A systems approach allowed the facilitator to step outside the boundaries of traditional roles and challenged others to do the same. The facilitator maintained the momentum of the change effort by using negotiation and diplomacy skills. Personal transformation was critical to the change effort as collaborative inquiry, reflection and advocacy replaced defensive thinking. The quality of the facilitator’s relationships improved within the school. Less time was spent convincing others of a unilateral point of view. The facilitator restructured assumptions that caused conflict, allowing a holistic view of interrelationships and patterns in the school, with service users at the core of service change.

5.3 Strengths of the project

Designing services in partnership with service users is in line with evidence based practise and mental health policy (DOHC, 2006). Throughout the process, the facilitator kept parents informed of changes to speech and language delivery in the school. Letters were sent to parents outlining the details of vocabulary groups taking place weekly in classrooms (Appendix 13).
The facilitator invited parents to a training workshop and coffee morning in order to build their capacity to facilitate change in their children’s communication skills. The parents were active participants in the evaluation process which will feed into further changes in the service. In essence, parents were partners in shaping their own speech and language therapy service in the school. They were effectively co-producing outcomes in collaboration with school staff and facilitator.

Teachers and Special Needs Assistants collaborated effectively with the facilitator. Successful outcomes were achieved in a school over burdened with systemic challenges and structural restraints, outlined in step four of section 3.4.2. McAuliffe & Van Vaerenbergh (2006) assert that the key component in any change initiative is the people involved. The quality of the relationships between all stakeholders determines the overall success. Teachers valued the speech and language therapy service (qualitative outcomes of results section in chapter four) and offered invaluable insights that will continue to improve the service. Furthermore, the weekly meetings facilitated a process of joint inquiry and reflection, a process often missing in busy schools. School staff reflected on their own understanding of language and communication and how to work with other agencies to support children. Staff discussed misunderstandings in an open way. Dissenting voices guided the change to the unique context of working with children with emotional and behavioural challenges. Staff suggested adaptations to groups according to the needs of individual children.
A trusting supportive environment evolved, where staff and facilitator flexibly adapted the system to open up innovative ways of working that benefitted everyone.

Additionally, the facilitator identified further drivers for change as the project evolved. In March 2014, The Department of Education selected the school for a whole school evaluation, providing further impetus to showcase collaborative work and document further changes needed in the education system. Collective action challenged a school culture wrecked by fragmentation and segregation. There are further challenges ahead in interagency work. Communication is central to overcoming these challenges, creating environments which allow the future to emerge (Scharmer, 2009), where people learn collectively from their limitations and successes.

5.4 Limitations of the project

The 7s model provided a framework to view limitations in the wider context (Appendix 5). Capacity building of staff skills and competencies was a central activity in this project. A significant structural weakness in this project was the unavailability of teachers and Special Needs Assistants for training workshops.
This staffing limitation impacted on the overall strategy of the change initiative as often misunderstandings emerged which could have been explored in greater depth at workshops. Training can change attitudes and improve joint working, addressing anxieties and exposing individuals to outside influences (O’ Reilly et al., 2013). While weekly meetings provided a platform to explore alternative behaviour management systems, training workshops would allow more detailed examination of this critical issue. Cooper and Jacobs (2011) advocate for the adoption of a whole school behaviour approach to facilitate positive behaviour and academic progress.

Consultation between mental health services, the National Educational Psychological Service (NEPS), the Special Education Support Service (SESS) and school staff would facilitate exploration and training on more evidence based approaches.

While Special Needs Assistants perform a care rather than an educational role, this involves significant interaction with children. Their role could be expanded to include educational support, similar to teaching assistant’s roles in the U.K. Third level training of Special Needs Assistants is essential, building their competencies and skills in working with children with communication and mental health challenges (Cooper & Jacob’s, 2011). The facilitator is in a pivotal role to guide future collaboration based on successes achieved in this synergistic collaboration. Negotiation is underway to restructure teacher’s availability for speech and language training. Competing objectives need careful balancing to ensure that the whole school language approach is not sidelined and segregated at critical times.
Segregation of sectors is a structural limitation in the wider context. Segregation breeds fear and mistrust. A blaming culture evolved, where mental health clinics and school adopted defensive stances to protect their positions and used budgetary cuts as excuses for non cooperation. A lose- lose mental model exists (Covey, 2004) where both agencies continue to operate in silos. However, both agencies are codependent in supporting children with mental health challenges. Mental health professionals refer to teacher’s evaluations of children’s presentation at school. Teachers need therapist’s advice to manage children’s behaviour challenges at school. Parents are in the middle adopting a holistic view of their child’s needs rather than splitting their child’s needs into education and health categories. The parents in this project value interagency cooperation “you can’t do one thing at a time (school and clinic). They are all meant to come in together to help the child” (Parent 3). It is time for a win- win mental model (Covey, 2004) to evolve across sectors, each agency supporting the other with advice, training and support, which ultimately benefits children’s outcomes. All stakeholders can be harnessed towards higher aims of mutual support and inter-dependency (Covey, 2004). This solution requires investment in resources and support systems.

There are few systems in place to help identify children with critical speech, language and communication needs in the school. The National Educational Psychological Service provides assessment and advice to the school for children with identified needs. This commissioned resource selects one or two children per year in this school, an inefficient and unsustainable approach to determining needs.
The speech and language therapy service relies on the educational psychology service to help identify children with language impairment. In the future, an Educational Psychologist could work with the facilitator to conduct a needs analysis of the entire school which would help to redistribute resources according to evidenced need. Objective measures of language and behaviour change for all children would be a valuable asset to this project but were not feasible due to limited resources. Qualitative measurement of changes in word maps allowed evaluation of language change. Rigorous measures are essential components in action research (Coghlan & Shani, 2013). More robust measures would involve standardised measurement of word knowledge using a selection of curriculum words (Clegg, 2014).

Furthermore, lack of support systems in the school’s wider context impact on the success of this whole school language approach. The Home/School/Community Liaison scheme is not available to children in special schools, despite the importance of parental involvement in providing an effective educational environment (Cooper & Jacobs, 2011). Lack of resources in one part of the system impacts on other parts. All elements are interrelated according to HSE model of change (Appendix 4). Nevertheless, there are clinical, research and policy opportunities in under resourced systems, which will be explored in the next section.
5.5 Implications for clinicians

On reflection of themes that emerged from focus group interviews in step three of section 3.4.2, parents want their children to develop communication that promotes social inclusion and independence, especially as they transition to secondary school. The children expressed how difficult it was to listen in their school environment. This message is important for teachers- the school environment can be modified to create a communication friendly environment. More research is required to align services alongside outcomes that service users (children and parents) value. The quality of relationships between service users and professionals improve as service users take pro-active roles in health and education. This project demonstrated that collaborating with children in research is a useful endeavour. Children actively contributed to strategies which impacted positively on their experience of speech and language therapy at school, important outcomes considering the lack of pupil voice in research, identified in section 2.3 and section 2.6.3.

Further action research cycles are required to modify the quality of relationships between school staff and children. As identified in section 2.5 of the literature review, Dockrell et al., (2012) developed a classroom observation tool to document how changes to teacher’s communication can enhance the quality of the interaction between teachers and children. Observation of teacher’s language captures what is happening in classrooms in real time.
These observations would inform future training. Improving the quality of teacher-child interaction is an important component in the whole school language approach. In fact, children with complex difficulties are not likely to improve if intervention is not functional or integrated with the involvement of parents (O’ Reilly et al., 2013). Special Needs Assistants could also be involved in this process.

In addition to training implications, there is a role for alternative behaviour and communication supports in this school. Communication from school to parents was frequently negative focusing on their child’s behaviour difficulties rather than exploring underlying causes of behaviour including children’s limited vocabulary and interaction skills. A positive aims diary is a method of documenting the incidence of positive behaviour during the day (Flynn, Shevlin & Lodge, 2012). This empowers children with praise and positive attention rather than drawing attention to negative behaviour, which reinforces their occurrence. Additionally, barriers in terminology contributed to on-going confusion among parents, school staff and facilitator (Salmon & Kirby, 2008). Communication and common care pathways are required to ensure that all individuals are working towards a common language to explain children’s profiles.
5.6 Implications for research

As outlined in the literature review, there is a lack of common care pathways between child and adolescent mental health services and schools which require further research. There are resource implications of interagency work as professionals work beyond the boundaries of their role, a challenging consideration in role defined cultures. Emerging evidence indicates that joint intervention has a positive impact on academic achievement and mental health (Dix, Slee, Lawson, & Keeves, 2012). Attwood, Meadows, Stallard, & Richardson (2012) provided computerised Cognitive Behaviour Therapy as a universal and targeted emotional health intervention in schools, resulting in immediate therapeutic benefits. However, the study was small scale and required more robust measurement. Similar to this project, it is premature to speculate on the effectiveness of school based interventions to promote mental health as further research is required to outline its effectiveness. The pivotal research question is how to embed emotional health interventions in school cultures and processes.

This project indicated that successful outcomes are based on mutual understanding, trust, communication and contextualised intervention. The effects of adopting a whole school language approach on children’s mental health can be explored in future research, as part of an overall strategy to mental health promotion in schools.
Sustaining whole school approaches is an ongoing challenge particularly when there are role hierarchies and power imbalances in the educational system. Existing educational structures marginalise service users from joint decision making. The powerful medical model resides in mental health clinics which minimise the voice of service users. Hints at resistance are framed in terms of confidentiality, which does not concern service users as much as mental health professionals. In fact, in this project, service users requested more communication rather than careful communication across agencies.

Further research could explore the barriers service users experience in accessing health and education services. Poor health literacy (defined in section 2.2) emerged as a barrier to parent’s engagement in this project. Community engagement would support those who are hard to reach and underserved by current systems. Future research and policy could provide frameworks for empowering service users with improved health literacy skills.
5.7 Implications for policy

Building on small successes is critical to sustaining momentum for further changes. Universal approaches can be adapted for use across sectors. Increasing demands on speech and language services require a re-conceptualisation away from the medical model to consider the impact of communication challenges on participation and well-being, in alignment with the World Health Organisation’s classification of functioning (WHO, 1998). A move towards adopting a public health approach will require a repositioning for the profession as central to mental health discourse (Law et al., 2013), to occupy positions of influence in relation to policy decisions. Speech and Language Therapists could target bullying and suicide prevention in schools. There are training implications for the profession that is beginning to adopt broader health promotion policies particularly in rural and developing world populations (McAllister et al., 2013).

Central to public health thinking is the need for understanding social and environmental causes of poor health. Poor health literacy compounds existing health problems as populations are unable to access services (Hester & Stevens-Ratchford, 2009). There were a number of families in this project with poor literacy skills which prevented them from evaluating the whole school language approach. Health promotion starts at policy level involving strategies for positive health messages in the community to whole government policy (Law et al., 2013).
Raising the profile of language and communication skills is an important protective factor for children. The International Communication Project (2014) provides a global online platform to raise awareness of communication impairment, adopting a universal stance to deal with common challenges, an important component of global leadership: Gill (2012:15) reports “great leaders discover what is universal and capitalize on it.” There is an increasing need for children leaving school to have competent communication skills to compete with peers at a global level. Speech and Language Therapists need to raise awareness in the general public of children and young people with speech, language and communication challenges. Parents in this project complained about the lack of awareness amongst friends and relatives, resulting in frustration, isolation, guilt and worry for their children’s futures.

Raising awareness of communication impairment in schools requires support at policy level. Collaboration between teachers and therapists was critical to the success of this project. Teachers have expert knowledge of the curriculum. They can provide Speech and Language Therapists with information about curriculum goals, ensuring intervention has academic relevance and provides opportunities for generalisation (Starling, Munro, Togher, & Arciuli, 2011). Speech and Language Therapists have expertise in receptive and expressive language. They can provide information about children’s communication to support learning with whole class adaptations across the entire curriculum. Integrated approaches ensures support for all children at a time when few teachers have resources for individual support.
The pervasive impact of language and communication impairment on children’s social, behavioural and emotional states requires Speech and Language Therapists to consult social services and juvenile justice organisations. Policies can promote interagency work in real time. Bryan and Gregory (2013) adopted a whole language approach when working with staff at a juvenile offending facility in the U.K. Staff benefitted from communication skills training to support young people with language and communication difficulties.

Further resource developments in the U.K. include accessible, on-line platforms that focus on raising the awareness of education and mental health professionals in the identification and impact of language impairment. The Communication Trust charity provide Speech and Language Therapists with a suite of resources promoting whole school language approaches. Speech and Language Therapists can modify health leaflets and online platforms aimed at children and young people including the use of more graphics and visual information to support understanding. This approach would empower young people to gain access to social networks, joining “digital natives” to communicate on global platforms, an important future skill in increasingly globalised economies.

Law, Reilly & Snow (2013:6) report that “Speech and Language Therapists are an untapped spring of prevention expertise but are not seen (by others or themselves) as agents of prevention and are rarely taught population-based primary prevention interventions in their training”.

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This project attempts to prevent a vortex affect to specialist services by adopting a universal approach. Ideally, this approach should be adopted before children enter the school system. Sure Start interventions in the U.K., provided communication support to pre-school children in areas of socio-economic disadvantage with the collaboration of voluntary, health and social services. A public health approach in Ireland would target early intervention, mitigate the pervasive effects of communication impairment and facilitate estimates of costs of language and communication impairment across the lifespan.

5.8 Conclusion

This project documented an integrated approach to improving outcomes for children with speech, language and communication needs. The model of collaboration adopted viewed children and parents as partners in shaping a new service designed around their needs. This involved consultation, collaboration, and empowerment of parents and children. Children as young as ten years gave important insights into what they want from a speech and language therapy service. They called for environmental adaptations to make it easier for them to listen in classrooms. Children have the competence to talk about what is important in their lives. Involving children in service planning promotes leadership and gives them the power to redress power imbalances in the school system (Flynn, Shevlin & Lodge, 2012).
Teachers can be empowered to address children’s needs by adopting a partnership approach with outside agencies. This project offered school staff the space for dialogue about the underlying causes of conflict across services and how school structures and ways of thinking exacerbate further conflict. The facilitator kept clinic management informed of the change initiative from the outset, breaking down communication barriers and highlighting the need to involve all stakeholders in the drive towards improved integrated outcomes for children.

A number of systemic and structural barriers continue to act as barriers to integrated services. Entrenched role cultures impact on mental models. Senge (2010) recommends surfacing these mental models in order to co-create better outcomes, and envision emerging futures (Scharmer, 2009). Alternating cycles of reflection and action gave the facilitator time and space to consider the impact of resistance and work with people’s assumptions around change. Acknowledging the impact of systemic factors on the local context ensured that universal and targeted approaches to intervention were relevant and of value to all stakeholders. Further developments will be planned, in the future, using the HSE model (2008) and the balanced system (Appendix 15) as guiding frameworks. The challenge is to adopt shared responsibility for better outcomes in children and move away from fragmented cultures to consolidation. This project demonstrated increased efficiency in the school when the entire workforce was galvanised to support better vocabulary outcomes for children, in equitable, sustainable ways.
Intervention can be put in place at an earlier stage which prevents the negative trajectory of communication impairment on a child’s life, a noble aim, achievable for all individuals. Adoption of globally distributed leadership harnesses all members of society, with benefits for society, particularly the vulnerable and marginalised. This project has also highlighted the need for multiple perspectives in shaping new services for clients. No one leader encompasses all qualities to make projects effective. Rather it is the balancing of multiple strengths and weaknesses that lead to success. Capacity building involves finding others with the capabilities you are missing, which promotes leadership throughout the organisation (Ancona, Malone, Orlikowski, & Senge, 2007).
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Appendix 1: Information Leaflet and Consent Form for Children

How you can help redesign the speech and language therapy service in your school.

I would like to invite you to join a project I am running in your school. My project involves how to help people with speech and language difficulties at school. I’m interested in finding out what things you like doing in speech and language therapy and what you would like to do more of. I am also interested in what things you find tricky in speech and language therapy and the things you would like to change. This is important because very little is known about speech and language therapy at school. Speech and Language Therapy usually takes place in clinics. I hope to find out more about which activities work best for you at school.
How many times will you meet with me during this project?

I will meet with you two times in the therapy room at your school. We will be doing some activities together which will help me to see how you understand what is said to you, how you talk about things, and how you make friends. Then a few weeks later, I would like you to join a group with four other children from your class.

What will the group session be about?

We will be talking about what is Speech and Language Therapy, what activities you would like to have in Speech and Language and also what you would like to change. There will be one group which last one hour. I will use a video recorder to help me remember everything you say.

What happens if you don’t want to talk about Speech and Language Therapy anymore?

We will stop straight away if you don’t want to talk about speech and language therapy anymore.
What should you do if you would like to join my project?

I have given a form to your parents/guardians. If you would like to join my project please sign this form with them. If you change your mind and don’t want to continue, that is no problem. If you have any questions please ask your parents/guardians to ring me.

I look forward to meeting you!
Consent form for Children

I agree to help _________ in her project about Speech and Language Therapy. I know that I will be going to the therapy room to see _________ for two visits and that we will be doing some communication activities together. I understand that I will then be participating in a group with four other children in my class to talk about Speech and Language Therapy. I know that we will be playing games and having fun with art and craft work. I am aware that the group will last one hour.

I know that______will be recording the sessions on a video recorder so that she will remember exactly what I have said. I know that if I change my mind and don’t want to talk about Speech and Language Therapy anymore that we can stop straightaway. I understand that if I have any questions about the project, I can ask_______.

Child’s Name:________________________

Child’s signature:_____________________

Date: ______________________________
Appendix 2: Information Leaflet and Consent form for parents

Dear parents/guardians

I am in my final year masters at Royal College of Surgeons. I am completing a thesis titled *Re-designing a speech and language therapy service in a school for emotional behavioural disorders: perspectives of service users*. I am interested in finding out information about your experience of speech and language therapy at school. Speech and Language Therapy is mainly provided in clinics. Very little information is known about the provision of speech and language therapy in schools in Ireland. I feel it is important to ask key people to contribute to this project so they have a say in the running of speech and language therapy in school. I am writing to invite you, your child and your child’s teacher to join the project. It will consist of the following

1. Assessment of your child’s speech and language skills over two forty minute sessions at school.
2. Participation in two focus group with other parents of children in your child’s class. We will be discussing what is speech and language therapy and your experience of speech and language therapy at school.
3. Your child’s participation in one focus group with four other children in his class. We will be discussing what activities are used in Speech and Language Therapy and what your child likes/dislikes about the activities.
4. One focus group with your child’s teacher, Special Needs Assistant and Resource teacher.
Focus groups and interviews will be videotaped and transcribed for analysis. You, your child’s and your child’s teacher’s identity will be strictly confidential. Your identities will be anonymous and will not be disclosed to anyone outside of the project. Information will be collected, stored and analysed in accordance with the Data Protection Act (1988) and Best Practice in Scientific Research. Benefits to participating in the project include a speech and language assessment for your child. I hope this project will highlight the importance of consulting key people when setting up and providing speech and language therapy in schools. I plan to complete the thesis in May 2014.

If you or your child does not wish to participate in the project, current or future service provision in the _______Clinic will not be affected. You or your child may withdraw from the study at any time. In some studies it has proven necessary to request participant withdrawal for various reasons. I am required to inform you that if necessary, your participation may be withdrawn without your consent. This study has been approved by the Royal College of Surgeons Institute of Leadership faculty and the St John of God’s Ethics Committee. Nothing in this document restricts or curtails your rights. Please contact me by ringing the school if you wish to participate in this project. I hope you will consider participating in this project. You will have the opportunity to voice your opinion on how to support your child with speech, language or communication difficulties.

Yours sincerely

__________
Consent form for Parents

Project Title: Re-designing a speech and language therapy service in a school for emotional, behavioural disorders: perspectives of service users

Investigator: __________

We understand that __________ will be assessed on a number of tests over two sessions at school. We are aware that as parents/guardians we will attend two focus groups designed to obtain information on our experiences of speech and language therapy at school. We understand that our child will take part in one focus group with four other children to explore their experience of speech and language therapy. We are aware that our child’s teacher will be contacted and will be involved in a focus group about speech and language issues in the classroom.

We are aware that all interviews will be videotaped and transcribed for later analysis. We understand that we may request a copy of the interview transcripts if we so wish. We are aware that videotapes and transcripts will be anonymous and stored in the Clinic, in accordance with the Data Protection Act (1988) and Best Practice in Scientific Research. We are aware that, in line with best practice recommendations, data obtained will be stored for five years and then destroyed. We know that all information will be treated with the utmost confidentiality and used for research purposes only. We are aware that data obtained will not be used in future unrelated studies without additional consent.
We understand that results of this study may be published in a relevant journal, but that no identifying information will appear in the article. We understand that our participation may be withdrawn at any time without consent.

**Declaration:**

We have read, or had read to us, the information leaflet for this project and we understand the contents. We have had the opportunity to ask questions and all our questions have been answered to our satisfaction. We freely and voluntarily agree to be part of this research study, though without prejudice to our legal and ethical rights. We understand that we may withdraw from the study at any time and we have received a copy of this agreement.

Parent/Guardian’s Name: ________________________________

Parent/Guardian’s Signature: ________________________________

Date: __________________________________________________

**To be completed by researcher**

**Statement of investigator's responsibility:** I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Investigator’s Signature: ________________________________

Date: __________________________________________________

Please return consent form to ______________________________
Appendix 3: Information Leaflet and consent form for Teachers

Dear Teacher,

I am a final year Masters student in the Institute of Leadership, Royal College of Surgeons. As part of my degree I am doing a thesis called “Re-designing a speech and language therapy service in a school for emotional, behavioural disorders: perspectives of service users”. I am interested in finding out what speech and language therapy service is like from the perspective of the key people who use the service. This is important because researchers know very little about speech and language therapy provision in a school setting in Ireland. Speech and Language therapy mainly takes place in clinics and other health care settings.

I am writing to invite you, as _______________’s teacher to join this study. I would like to meet you in your school with the resource teacher and Special Needs Assistant, for about an hour and a half. I will be asking you some questions about your experiences of supporting children with speech, language and communication difficulties in the classroom. I am interested in your understanding of speech and language difficulties, your experience of the potential challenges in working with children with these difficulties and the impact on your teaching practice. __________ and his/her parents have already participated in focus groups which explored their experiences of speech and language therapy at school. I will be videotaping the focus group and transcribing it for later analysis.
Your identity will be strictly confidential and will not be disclosed to anyone outside of the study. Information will be stored for five years and then destroyed, in accordance with the Data Protection Act (1988) and Best Practice in Scientific Research. In some studies it has proven necessary to request participant withdrawal for various reasons. I am required to inform you that if necessary, your participation may be withdrawn without your consent. This study has been approved by the faculty at the Institute of Leadership, Royal College of Surgeons and the St John of God’s Ethics Committee. Nothing in this document restricts or curtails your rights.

_____________’s parents/carers have given their written consent to contact you.

I would be very grateful if you could read and sign the enclosed consent form and send it back to me at school. Please don’t hesitate to contact me any time on ___________, if you have any queries.

Yours sincerely,

_____________________

______________________
Consent Form for Teachers

**Project Title:** Re-designing a speech and language therapy service in a school for emotional, behavioural disorders: perspectives of service users

**Investigator:** ______________________

I understand that I will be taking part in a focus group interview with ______. This focus groups will last about one hour and will be arranged at a time and date that is most convenient to me. The purpose of this interview is to explore my experiences of supporting children with speech, language and communication difficulties in the classroom. I am aware that the focus group will be videotaped and transcribed for later analysis. I understand that the videotape and transcript will be anonymous and stored in accordance with the Data Protection Act (1988) and Best Practice in Scientific Research, that all information will be treated with the utmost confidentiality and used for research purposes only. I understand that I may request a copy of the focus group transcript.

I am aware that data obtained will not be used in future unrelated studies without additional consent. I understand that results of this study may be published in a relevant journal, but that no identifying information will appear in the article. I know that my participation may be withdrawn at any time without consent. I am aware that, in line with best practice recommendations, data obtained will be stored for five years and then destroyed.
Declaration:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

Teacher’s Name: _________________________________
Teacher’s Signature: _____________________________
Date: _________________________________________

To be completed by researcher

Statement of investigator’s responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Investigator’s Signature: _____________________________
Date: _________________________________________

Please return consent form to _______________________________
Appendix 4: HSE change model (HSE 2008b)
Appendix 5: 7S model (Peters, & Waterman (1984)
Appendix 6: Children’s Topic Agenda

1. Introduction

Introduction of facilitator and participants

Introduce the research aims and objectives: what do you think about Speech and Language Therapy at School

Outline the rules of the group including confidentiality, speak one at a time, video recording, everybody will be asked for their view, open debate

2. Discussion Topics

What is Speech and Language Therapy (SLT)?

What do you like about SLT?

What do you dislike about SLT?

What are good talking times/places/people?

What makes them good?

Which talking times are bad?

What makes them bad?

What would make them better?

What helps you talk better in class?

What is tricky in SLT?

What would you like to change about SLT?
3. Summing Up

Thanks for participation

Invite back to next focus group
Appendix 7: Parent Topic Agenda

1. Introduction

Introduction of facilitator and participants

Introduce the research aims and objectives

Outline the rules of the group including confidentiality, speak one at a time, video recording, everybody will be asked for their view, open debate

2. Discussion Topics

What is your understanding of the speech and language therapy service at school?

What are speech, language, communication difficulties?

Main challenges for your children with these difficulties in the classroom

What kind of support do you need to help your child with speech, language and communication needs?

Is there anything that makes it difficult for you to avail of speech and language therapy support and training? What helps?

What benefits have there been to you from having Speech and Language Therapy in the school?

Is there anything you would like to change about Speech and Language Therapy in the school?

Have you anything to add?
3. Summing Up

Thanks for participation

Invite back to next focus group
Appendix 8: Teacher Topic Agenda

1. Introduction

Introduction of facilitator and participants

Introduce the research aims and objectives

Outline the rules of the group including confidentiality, speak one at a time, video recording, everybody will be asked for their view, open debate

2. Discussion Topics

What is your understanding of the speech and language therapy service at school?

Main challenges for these children in the classroom

Have you been involved in referring children to Speech and Language? How does this process work?

What kind of support do you need to help children with speech, language and communication needs?

Is there anything that makes it difficult for you to avail of speech and language therapy support and training? What helps?

What benefits have there been to you from having Speech and Language Therapy in the school?

Is there anything you would change about the Speech and Language Therapy service in the school?

Have you anything to add?

3. Summing Up

Invite back to next focus group
Appendix 9: Outcome Measure Child Questionnaire

Name:  
C.A:  
Date:  
Therapy attended:  

1. What is my job here in this school?
______________________________________________________________
______________________________________________________________
______________________________________________________________

2. Why do you need to see a speech and language therapist?
______________________________________________________________
______________________________________________________________
______________________________________________________________

3. What was it like having the speech and language therapist in your class?
______________________________________________________________
______________________________________________________________
______________________________________________________________

4. What did you like best about the group?
______________________________________________________________
______________________________________________________________
______________________________________________________________

5. What did you not like?
______________________________________________________________
______________________________________________________________
______________________________________________________________
6. What did you learn?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

7. Is there anything else I can help you with?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

8. How could we make the next group even better?
   ________________________________________________________________
   ________________________________________________________________
Appendix 10: Outcome Measure Parent Questionnaire

Dear parents/guardians, I would be very grateful if you could fill in the following questionnaire. This will assist in planning more therapy for your child. Thank you very much for your help!

1. Do you understand why your child is attending speech and language therapy groups in the classroom?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. A speech and language therapist working in the classroom will benefit my child’s interaction and learning. Please circle.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Don’t know</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

3. Do you feel there was any change in your child’s vocabulary over the course of the therapy group? If so, please explain briefly.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. What do you think are the benefits of delivering speech and language therapy in school for your child? For you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Did you attend the speech and language therapy workshop? If yes, do you feel you could use the strategies discussed at home with your child?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
6. Please give any additional comments that may help us in the planning and running of future groups

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Appendix 11: Outcome Measure Teacher/ SNA Questionnaire

Dear Teachers and Special Needs Assistants, I would be very grateful if you could fill in the following questionnaire. This will assist in planning further speech and language therapy groups in your classroom. Thank you very much for your help!

1. What is your overall impression of a speech and language therapist working in the classroom to support children’s vocabulary skills?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. I feel the group addressed the children’s needs. Please circle.

   1                      2                         3                                4                           5
   Strongly          Disagree                      Don’t know                      Agree                      Strongly
   Disagree

3. Have you noticed a change in the children’s vocabulary over the course of the group?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. Do you think that you could incorporate word maps into your work with the children?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. What do you think are the benefits of delivering speech and language therapy in school for children? For school staff?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
6. What are the challenges of delivering speech and language therapy in this school?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

7. What support measures/resources would make it easier for your school to accommodate speech and language therapy in the future?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

8. Would you like further training on speech and language therapy?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Appendix 12: Management Questionnaire - please refer to summary report

1. From what you have read of this organisational development project, how useful do you feel this is to the work of the organisation?

________________________________________________________________
________________________________________________________________
________________________________________________________________

2. What would help progress this development?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

3. Do you have any concerns about this development? How can these concerns be addressed?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

4. This project will have a positive impact on the children's overall development in the school

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Don’t Know</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>
Summary Report to School and Clinic Management March 2014

Re-designing the SLT service in __________

Background:

Speech and Language Therapy (SLT) have initiated an organisational development project to redesign how SLT is provided to the school. Focus groups were conducted in December 2013 to gather the views of one classroom of children, their parents/guardians and a group of teachers/special needs assistants. An action plan was established to reflect the main themes which emerged from the focus groups. A whole school language approach was adopted to improve all children’s language skills within a supportive educational environment.

Intervention:

The key activities of the implementation phase from January- March 2014 were:

- Parent training workshops on Speech and Language Therapy
- Classroom intervention and coaching in order to encourage the use of word maps (visual strategy) and activities to support vocabulary development
- Attending weekly meetings with teachers in order discuss benefits/challenges of intervention
- Reviewing and re negotiating action plan
Plan:

- Continue weekly classroom groups in collaboration with teachers and Special Needs Assistants
- A group of parents/guardians will meet monthly in the school to discuss further ideas on collaborating with speech and language therapy and education
- Training workshops for all school staff on speech and language therapy
Appendix 13: Parent letter
Vocabulary Skills Group

Session 3

Each week we will be bringing home a sheet to help parents/guardians learn about what we have been doing in the group. The focus of the next few sessions is to explore all the ways that one can describe words, and identify the many characteristics that belong to each word using word maps. The children will have one word map for homework and will be expected to complete it and bring in the following week. The basics characteristics of words include:

- What is the meaning of the word?
- What does it look like?
- What sound does it make?
- What does it taste like?
- What does it feel like?
- What does it smell like?
- What does it do?
- Where would you find it?
- How would you use it in a sentence?
- What does it rhyme with?
- How many syllables does it have?
- What word is it related to?

After this we played a variety of team games together.
### Appendix 14: Multiple Stakeholder Evaluations, response rates & analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Child</th>
<th>Parent</th>
<th>Teacher/SNA</th>
<th>School Management</th>
<th>Clinic Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluations distributed</strong></td>
<td>5</td>
<td>35</td>
<td>20</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Response Rate</strong></td>
<td>100%</td>
<td>21%</td>
<td>35%</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Improved vocabulary skills</td>
<td>70% agree</td>
<td>60% agree</td>
<td>50% agree</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Change in class environment</td>
<td>50% would like more games</td>
<td>12% would like more visuals</td>
<td>100% use word maps in class</td>
<td>20% support the use of visual cues</td>
<td>100% support use visual cues</td>
</tr>
<tr>
<td>Perception of SLT</td>
<td>50% report SLT was fun</td>
<td>80% agree SLT supports learning</td>
<td>50% need more consultation with teacher</td>
<td>100% report SLT supports learning</td>
<td>100% agree SLT positive impact on child’s development</td>
</tr>
<tr>
<td>Resources support SLT</td>
<td>N/A</td>
<td>70% full time SLT required</td>
<td>50% support more technology</td>
<td>100% support new efficient service</td>
<td>100% support new structure &amp; system</td>
</tr>
<tr>
<td>Training workshops</td>
<td>N/A</td>
<td>70% found it useful</td>
<td>30% don’t have time to attend</td>
<td>100% support staff training</td>
<td>100% support training</td>
</tr>
</tbody>
</table>
Appendix 15: The Balanced System (Gascoigne, 2012)