VOLUME 2

Professional Practice Reports

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CONTENTS

INTRODUCTION

This volume presents four Professional Practice Reports (PPRs) undertaken as part of the three year professional training programme in Applied Educational and Child Psychology at the University of Birmingham (2011-2014). These PPRs were completed in one Local Authority (LA) within the West Midlands in which I was employed as a Trainee Educational Psychologist (TEP) during the second and third years of the course. This chapter will briefly outline each of the PPRs in turn and will conclude with implications for theory development and professional practice, and highlight the unique contribution to knowledge.

1.1 PPR 1: An exploration of how a Behavioural, Emotional and Social Difficulties (BESD) special school provides for pupils with Attention Deficit Hyperactivity Disorder (ADHD)

This PPR focused on evaluating a specialist setting that catered for children and young people with complex needs. Adopting a case study methodological framework, I aimed to explore the how a BESD special school within the LA provided for pupils who had received a diagnosis of ADHD. Through a literature review, strategies that were seen as good practice for these pupils were identified. Data was collected through structured observations, semi-structured interviews with staff members and an examination of the school's behaviour policy. The findings suggested that the support the school provided for pupils with ADHD matched the areas identified as good practice within the research literature. Limitations of this

research, along with implications for the practice of Educational Psychologists (EPs) are presented, along with ideas for future research.

1.2 PPR 2: Is Brief Cognitive Behavioural Therapy (BCBT) an effective approach for helping children cope with separation anxiety? A case study example.

This PPR focused on the delivery of a therapeutic intervention with one young person. A BCBT approach was used with one young person who had been identified by school staff as displaying symptoms that could be associated with a clinical diagnosis of separation anxiety disorder (SAD). This PPR presents a case study example, describing the needs of the young person, my formulation and the approach to intervention that was adopted. The approach was evaluated using a range of pre-and post-intervention measures. The findings of these measures are presented, and the effectiveness of adopting such an approach to intervention with young people with SAD is discussed. The role of EPs in delivering therapeutic interventions is also considered.

1.3 Assessing family strengths: An approach based on family resilience

The third PPR focuses on a method of family-based assessment and intervention. This PPR introduces the idea of strengths-based approaches, as opposed to more traditional deficit-based approaches. A strengths-based approach to identifying strengths within a family was developed, based on the Key Processes in Family

Resilience Model developed by Walsh (2006). This took the form of a set of interview questions and accompanying rating scales that were trialled with a small sample of four parents. The approach was also evaluated using a set of questions which explored the parents' views on the strengths-based approach. The findings from this PPR were positive and suggested that the tool developed was useful at helping parents to identify the strengths within their families. Implications for working with families and EP practice using strengths-based approaches are considered.

1.4 PPR 4: Increasing the capacity of Youth Offending Team (YOT) workers to identify speech, language and communication needs (SLCN) using an organisational development (OD) action research model

The final PPR focuses on a planned change process within an organisation. The organisation was the YOT within the LA in which I was employed. Using an OD action research model, I aimed to increase the capacity of the YOT workers to identify the young people that they were working with that had SLCN. Using a screening tool that had been used in two other YOTs in the UK, I assisted three case managers within the YOT to pilot these. Feedback was collated as part of the action research process. Findings relating to their capacity to identity young people with SLCN are presented, along with comments on the utility of adopting on OD action research model to bring about change within an organisation.

1.5 Implications

The findings from the four PPRs presented within this volume all illustrate a unique contribution to knowledge and have implications for the practice of EPs. PPR 1 provides evidence of provision for pupils with ADHD within one educational setting; the findings may have implications for developing good practice within other, similar settings. EPs may be well placed to help educational settings identify and implement the strategies that could be viewed as good practice, due to their research skills.

PPR 2 highlights a case study example which provides support for the effectiveness of EPs implementing a CBT intervention with young people with symptoms that could be associated with SAD.

PPR 3 provides a tool for identifying strengths within families that could be used by EPs as part of their practice. It also suggests that EPs may benefit from adopting strengths-based approaches within other areas of their practice.

PPR 4 offers findings regarding the challenges and opportunities of implementing change within an organisation. This has implications for EPs involved in systemic work, and provides support for the model utilised within this project. This PPR also suggests that EPs may be well placed to support YOTs, particularly in relation to identifying young people with additional needs, but that further work is needed to promote their involvement within these settings.

PPR 1: An exploration of how a Behavioural, Emotional and Social Difficulties (BESD) special school provides for pupils with Attention Deficit Hyperactivity Disorder (ADHD)

Abstract

This case study aimed to examine the support provided for pupils with a diagnosis of ADHD within a BESD special school. In particular, whether the support matched identified good practice from the research literature, whether staff viewed pupils with ADHD as having different needs from those without ADHD and the strategies and features of the classroom that staff considered important when supporting these pupils. Data was collected using structured observations, semi-structured interviews and by examining the school's behaviour policy. The findings suggested that the school's support did match the good practice from the research literature. Some staff viewed the pupils with ADHD as requiring more support than pupils without a diagnosis, but largely viewed their needs as similar to those with any behavioural difficulty. Thematic analysis of the interview data suggested that staff viewed supportive adults (staff and parents) with sufficient training and information, interventions (which were indivualised and supported both behavioural and social development) and changes to the environment (such as seating arrangements and high staff: pupil ratio) as key to supporting pupils with ADHD and other pupils with BESD. Limitations of the research, as well as implications for the role of the EP and considerations for future research are discussed.

Introduction

In recent years, there has been increasing concern amongst psychologists regarding the medicalisation of children's behaviour (e.g. Traxson, 2010). Of particular concern is the apparent surge in children receiving diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and the notion that ADHD is becoming an increasingly common childhood condition (e.g. Brown, 2007; British Psychological Society, 2011). As such, ADHD and considerations around patterns of treatment and intervention are of particular relevance to the educational professional. In particular, I was interested in exploring the support offered to pupils with ADHD in schools within my local authority, aside from pharmacological treatment.

National Context

The National Institute for Clinical Health and Excellence (NICE, 2009) published guidelines on the diagnosis and management of ADHD in children, young people and adults in an attempt to ensure equality of access to diagnosis and treatment across the UK. These clinical guidelines aim to assist healthcare professionals when making decisions regarding diagnosis and treatment pathways (NICE, 2009). These guidelines focus on the importance of a multi-disciplinary approach to diagnosis and suggestions for treatment including psychological interventions and parent training, interventions for children in educational settings and dietary interventions, as well as pharmacological treatments (NICE, 2009). However, these guidelines are non-statutory and may not always be followed by professionals. For example, the guidelines suggest that: 'Drug treatment is not indicated as the first-line treatment for

all school-age children and young people with ADHD' (p.367, NICE, 2009). However, a high number of young people who have a diagnosis of ADHD have been prescribed medication to treat their condition as a 'first-line of treatment' (Traxson, 2010), without other forms of treatment being considered. This may reflect the guidelines' claims that they do not aim to replace 'professional knowledge and clinical judgment' and that the guidelines may not be 'appropriate' or 'applicable' for all people in all situations (p.11, NICE, 2009). These claims, in my opinion, leave the diagnosis and treatment of ADHD open to the subjective opinions and beliefs of individuals.

Another issue of national relevance is the pending publication of the fifth version of the Diagnostic and Statistical Manual (DSM-5) of the American Psychological Association, due in 2013. The BPS (2011) published a response to DSM-5, highlighting their concerns regarding the medicalisation of 'natural and normal responses' to everyday experiences (p.2). With regards to ADHD, the BPS (2011) express some apprehension concerning the 'scientific validity' and the 'utility of diagnosis' of the condition (p.4); they also argue that the behaviours often associated with ADHD may in fact be construed as normal responses to challenging environmental or relational situations. In particular, there is also concern that the DSM-5 will include 'Other Specified Attention Deficit/Hyperactivity Disorder' (BPS, 2011); this may lead to many more children and young people being given diagnostic labels such as these, whereas in the past they would not have met the criteria for ADHD and so would not have received any particular diagnosis. With the likelihood that DSM-5 will be published later this year and will be influential in the systems for

diagnosis within the UK, support for young people with ADHD is a particularly current and relevant issue

Local Context

As a Trainee Educational Psychologist (EP) working within a multi-agency team, I have my own allocation of schools. However, the Local Authority within which I am currently working has a range of specialist provision, including four pupil referral units (PRUs) and seven special schools, catering for a range of complex needs.

I was particularly interested in looking at the support available for pupils with ADHD and decided to approach a BESD special school (which shall henceforth be known as Old Hill Special School to preserve anonymity) to conduct an exploration of the provision that they offer. This particular school was chosen as during a meeting with the school's head teacher and Behaviour Intervention Leader as part of my induction, I discovered that in 2011, the school had featured in an ITV1 documentary (Tonight, broadcast on Thursday 28th July 2011) looking at treatment for pupils with ADHD. The school offers a clinic jointly run by the Local Authority and the NHS; health and educational professionals, in collaboration with parents, carry out detailed assessments of the pupil and if diagnosed with ADHD, offer interventions including not only medication, but also support in school, at home and in the community. The school and their clinic had been identified as an example of 'good practice' in terms of the way they diagnose and offer support to pupils with ADHD. Due to this, I decided it would be useful to look at the type of interventions and support that are

offered within the school on a day-to-day basis for all pupils with a diagnosis of ADHD, and compare this with examples of 'good practice' for interventions from the published literature.

This report starts with an examination of recent research literature, detailing good practice with regards to school-based interventions for pupils with ADHD. This literature review led to three key research questions which I wished to explore further. I then provide details of my research study, which involved approaching Old Hill Special School as a case study where I conducted a number of observations, interviewed members of staff and examined their behaviour policy. The focus of this case study was to examine the support within the school for pupils with ADHD and gather the views of staff members with regards to the needs of these pupils and the support they feel is of greatest benefit. I then present the findings of this research, followed by a discussion, outlining how they relate to my research questions and their implications.

Literature review

My literature review was conducted using the University of Birmingham's electronic library search feature, searching for key terms such as 'ADHD and treatment' and 'ADHD and intervention' published in the last twenty years. Literature was included if it related to supporting school-aged children with a diagnosis of ADHD and particularly if it was from a psychological or educational perspective, as these areas were the focus of the present study. Literature from the 1990s to the present day

was included. This decision was made as it appeared that interest in educational provision and strategies for pupils with ADHD gained increasing attention during the 1990s and early 2000s, whilst the most recent research has focused on the medicalisation of the condition and the ethics of this. Articles from the special edition of the journal Educational and Child Psychology published in 1997 that focused on ADHD were of particular relevance due to their emphasis on intervention.

The literature review will consider how ADHD is defined and how pupils with this condition can best be supported within educational settings. Research questions raised by this review are then presented.

Defining ADHD

The BPS (1996) defined ADHD as a condition in which the behaviour of the child 'appears inattentive, impulsive and overactive to an extent that is unwarranted for their developmental age and is a significant hindrance to their social and educational success' (p.13). This definition relates to the diagnostic criteria detailed in the USA by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994): inattention, hyperactivity and impulsiveness, which should have been present for at least six months in more than one setting (e.g. home and school).

Since the publication of the BPS' (1996) 'psychological response to an evolving concept', there has been much debate both in the media and academic circles regarding ADHD, its causes and whether people 'grow out of it' (Reason & Sharp, 1997). Questions have also been raised over approaches to treatment and differing diagnostic standards across the world (Reid & Maag, 1997) and even whether the condition actually exists (Atkinson, Robinson and Shute, 1997). In fact, Kendall (2000) suggests that 'during the last decade … ADHD has been one of the most widely observed, described, studied, debated and treated childhood disorders' (p.65). As such, the concept of ADHD is surrounded by controversy (Cooper, 2008).

Recent debates, both in the UK and worldwide, have focused on the over diagnosis of ADHD and the over medicating of children with this condition (Traxson, 2010). A search of national and international media coverage of ADHD in the past five years highlights the increasing level of interest in debate: for example, Newmark and Koplewicz (2013) debate whether the condition is over diagnosed and whether medications for ADHD are prescribed unnecessarily. The Press Association (2013) describe a 56% increase in prescriptions for ADHD treatments in the UK since 2007. Swaine (2013) also highlights the increase in diagnoses and medical prescriptions for this condition in the USA. Doward and Craig (2012) report that prescriptions of Ritalin (one of the most commonly prescribed medications for ADHD) have quadrupled in the last decade and are being given to children as young as three years old. Szalavitz (2012) expresses concern that almost 4% of American children have been prescribed stimulant drugs for the treatment of ADHD. Paton (2010) reports that £31million of UK taxpayers' money has been spent on drugs to treat

ADHD. This small selection of articles published in newspapers and online in the past three years highlights the controversy surrounding ADHD and its treatment.

Academic research has also contributed to this debate. Clarke and Lang (2012) analysed the content of internet blog sites used by parents to discuss the medication for their children with ADHD; they found that of the 165 posters on the sites, the vast majority saw medication as the best course of treatment for their children. They found that those posters who expressed alternative views were often criticised or insulted by other posters (Clarke & Lang, 2012). These results are rather alarming, since medication should not be used as the first-line of treatment for ADHD (NICE, 2009). Lakhan and Kirchgessner (2012) describe the potential adverse effects of taking stimulant drugs on areas such as memory, processing speed and reaction time and highlights the dangers of large doses of such drugs, including cardiovascular problems, psychosis and seizures. Research such as this highlights the importance of caution when diagnosing and prescribing stimulant medication for ADHD.

It is not within the scope of this report to contribute in depth to these debates, as they are not particularly helpful to the children diagnosed, rightly or wrongly, with this condition or their families. Instead, this report aims to identify good practice from the research literature for supporting children with ADHD, particularly in the school environment. This area is perhaps the most relevant to the professional practice of

EPs; EPs may be asked to provide advice as to how these children can be best supported within the school environment.

Similarly, EPs are likely to be involved in the multi-disciplinary process that is recommended for the assessment and diagnosis of ADHD: the BPS (2000) state that the multi-disciplinary team should 'ideally include teacher, health visitor, psychologist and physician (including psychiatrist)' (p. 12) and that any diagnosis should be based upon evidence gathered from all of the relevant professionals. However, it is noted that it is likely that a medical professional would give the formal diagnosis, rather than an EP, perhaps due to the idea that ADHD is a medical condition that can be treated with medication (BPS, 2000). It could be argued, however, that EPs play a key role in intervention compared to medical professionals; as EPs have close links with schools, parents and families, as well as children, they may be best-placed to offer advice and support regarding intervention once a diagnosis of ADHD has been given, as they are not restricted to a clinical or medical setting and can be more flexible in their approach.

There is a vast body of research relating to ADHD and interventions for the condition. From this research, along with information from NICE (2009) and the BPS (2000), I have chosen to focus on the interventions and support that can be implemented in educational settings. From the literature review, seven key areas for supporting pupils with ADHD were identified: training for teaching staff, changes to the learning

environment, behavioural interventions, behavioural monitoring, social skills interventions, individualised support and support for parents.

Training for teaching staff

NICE (2009) suggest almost 4% of boys and 1% of girls in the UK have ADHD. Due to this reported prevalence, it is likely that all teachers and education staff, in mainstream as well as special schools, will come into contact with many pupils with a diagnosis of this condition throughout their career. Research conducted by Maras and Redmayne (1997) highlighted that there are many misconceptions held by teachers with regards to ADHD, its symptoms and treatment. As it is likely that pupils with ADHD will have a significant impact on the behaviours, interactions and learning that occur in the classroom, it seems that all staff within schools should have a good understanding of ADHD and how to manage pupils with this condition. It seems unreasonable to expect them to be 'experts' (Maras & Redmayne, 1997), as they are likely to be required to cater for the needs of a wide range of pupils. However, a basic understanding of the condition and the type of support that pupils with this condition may need would be beneficial.

Wheeler et al. (2008) surveyed a number of schools within one Local Authority (LA) in the UK, gathering information regarding the prevalence of ADHD, issues of diagnosis and school training needs. Within this particular LA, only 12% of teachers indicated that they had previously received training in ADHD but the 'majority' (p.173, percentage not given) showed an interest in receiving additional training. The claims

made by this study should be read with caution; the data collected only relates to one LA, whose characteristics are likely to differ from other LAs, and so the findings must be generalised with caution. Similarly, despite a fairly high response rate (94%, p.168), there were 'uncompleted questions on some questionnaires' (no percentage given, p. 170); this may mean that data regarding schools' previous training and future training needs were not recorded. Despite these limitations, the findings from this study, when taken as a case study example provide some indication of the fairly low amount of training available for teachers with regards to ADHD.

Why is such training important? Miranda et al. (2002) carried out a randomized control trial providing 'psychoeducation' about ADHD for teachers. They found that by providing teachers with more information regarding ADHD, their knowledge of ADHD increased, they were more able to identify pupils displaying ADHD symptoms and the pupils with ADHD in their class' academic performance actually increased as they had a greater knowledge of strategies to support those pupils. Although this particular study was conducted in Spain, the findings still have implications regarding the importance of training teachers in ADHD and appropriate strategies within the UK; the benefits of similar teacher training on pupil's self-efficacy (Hepperlen et al., 2002), academic performance, social skills and behaviour management (Kos et al., 2006) is well-documented.

Changes to the learning environment

Connor et al. (1997) produced guidelines for good practice for education staff in Surrey, focusing on the management of the condition rather than diagnosis, and giving thought to environmental factors rather than within-child factors. One of their key findings was that changes to the learning environment, whether that be the physical environment or changes to methods of teaching, could be beneficial for pupils with ADHD. Strategies they suggest include: use of a quiet area, differentiation of task and pedagogy, and use of learning contracts (Connor et al., 1997). However, Connor et al. (1997) do not appear to have 'tried and tested' the strategies they are suggesting as beneficial, but instead are taking research from other authors and presenting it as 'good practice'.

For this reason, it is important to consider other examples from the research literature that suggest changes to the learning environment may be beneficial for pupils with ADHD. There are many strategies suggested for supporting pupils with ADHD in the classroom including the use of a quiet zone or time out area, moving the pupil away from potential distractions, and short activities with a high level of structure for the day (DuPaul & Stoner, 2003). Evidence suggests that these strategies all aim to keep the pupil on-task and paying attention to the activities presented to them.

DuPaul and Weyandt (2006) published a paper examining school-based interventions for pupils with ADHD. They examined what they termed 'academic interventions' (p.167), which include modifications to teacher instruction and

computer-based teaching methods and provided research findings that showed the positive impact that these methods can have. However, they suggest that only a few empirical studies have been conducted to examine the impact of these types of intervention (DuPaul & Weyandt, 2006). Similarly, the majority of research contained in the review appears to have been conducted in 'clinical' settings. Thus, findings from such research may not generalise to 'real world' settings, such as the classroom. It would seem that, although changes to the learning environment have been shown to be beneficial for pupils with ADHD, additional research is required in this area in order to determine the exact impact that these strategies can have.

Behavioural interventions

Many pupils with ADHD display challenging behaviour within the classroom. For this reason, another area in which there exists a plethora of suggested strategies for pupils with a diagnosis of ADHD is that of behavioural interventions. These strategies aim to support pupils' impulsive behaviour and reduce hyperactivity (DuPaul & Stoner, 2003). Suggested techniques which have a positive impact on the behaviour of pupils with ADHD include carrying out a functional analysis of behaviour (DuPaul & Ervin, 1996), antecedent-based and consequence-based strategies (DuPaul & Weyandt, 2006), positive reinforcement and token economies (Kapalka, 2008), and so on. These techniques are widely connected with managing any kind of behavioural difficulty, and are not necessarily specific techniques for use with pupils with ADHD.

Behavioural monitoring

One behavioural technique that may meet the needs of pupils with ADHD more specifically is that of behavioural monitoring and encouraging the pupil to take responsibility for managing their own behaviour and show self-control in relation to the associated impulsivity and hyperactivity. The NICE (2009) guidelines recommend self-monitoring of behaviour techniques for pupils with ADHD; they suggest that such techniques allow the pupil to adopt a more 'planned and reflective way of thinking and behaving' (p.152).

Fabiano et al. (2009) studied the impact of utilising 'daily behaviour report cards' as a behavioural monitoring technique for pupils diagnosed with ADHD. These cards involve setting individual targets with the pupil and the teacher providing immediate feedback at the end of each activity as to whether the pupil has met their targets. This is then recorded on the card and can be reviewed at the end of each day or week, with a reward being provided if the pupil has met their targets during a certain number of activities. Fabiano et al. (2009) position these report cards as a reliable, valid and effective method of improving behaviour in pupils with ADHD. Their study only focused on children within the 5-12 year old age range, but it is likely that the use of report cards would also be effective with older children: positive reinforcement of behaviour has been shown to be effective method for behaviour modification across the entire school-age range for pupils with ADHD (DuPaul & Stoner, 2003).

Behavioural self-management strategies (such as self-evaluation, goal-setting and self-monitoring) have been shown to be effective in controlling a range of behaviours, including attention to task, accuracy of work and social interactions (DuPaul & Weyandt, 2006). However, it is likely that behavioural monitoring and self-management strategies are only successful for pupils with milder symptoms of ADHD; it is unlikely that pupils who display high levels of impulsivity and hyperactivity would be able to effectively manage their behaviour independently, without additional support from others.

Social skills interventions

Social skills interventions are also considered an effective way to manage the symptoms of ADHD. Medication for ADHD has been linked with poorly developed social skills (e.g. Borg, 2009; Exley, 2008) and pupils diagnosed with the condition have been found to be less adept at problem-solving in interactions with their peers (Borg, 2009). Thus, it seems that social skills interventions should be an important aspect of the management of ADHD. The NICE (2009) Guidelines recommend social skills training that 'teaches the micro skills of social interaction' (p.153).

Pupils with ADHD often experience difficulties in forming and maintaining peer relationships; in fact, one of the diagnostic criteria in the DSM-IV is that the symptoms lead to impairment in social, academic or occupational domains (APA, 1994). These social difficulties may be a result of an inability to control impulsivity when interacting with peers, higher levels of aggression and/or a lack of ability to

follow social rules. Due to this, pupils with ADHD may benefit from interventions that directly teach social skills or support their development (DuPaul et al., 2006).

Watson and Marr (2003) describe case study evidence that setting up a breakfast club for children with emotional and behavioural difficulties in a special school can have a positive impact on the development of their social skills. Around half of these children had a diagnosis of ADHD and school staff noted improvements in the interactions between the children after the club had been running for eight weeks. Although the evidence presented in this case study appears anecdotal, and perhaps not generalisable beyond the bounds of the presented case, the positive effects of providing pupils with the opportunity to interact with their peers, outside of the classroom but in a safe and nurturing environment, can have a positive impact (Watson & Marr, 2003).

Individualised support

Research evidence suggests that any interventions should be tailored to the individual needs of the pupil with ADHD (DuPaul & Stoner, 2003). Pester (2002) describes his study and highlights the importance of gathering as much information as possible about the individual pupil to aid effective intervention planning. This latter study utilised a case study design, which may mean that one cannot generalise to other cases. However, the use of mixed methods, such as individual interviews, staff reports and observations, allow for triangulation and thus ensure greater reliability of findings (Bryman, 2008). Similarly, a range of other sources have suggested that

pupils with any type of behavioural difficulty would benefit from support tailored specifically to their individual needs (e.g. Frederickson & Cline, 2010; Connor et al., 1997; DuPaul & Ervin, 1996).

Support for parents

As well as providing support for the pupil with ADHD, it is also recommended that additional support is given to the parents due to the well documented difficulties that families with children with ADHD experience (Johnston & Mash, 2001). NICE (2009) advocate the use of 'parent education' programmes. The guidelines suggest that parents should be taught 'behaviour therapy techniques' to use with their children (p.152), including techniques based on behavioural learning theory and play therapy, and also increase their knowledge and confidence with regards to supporting their child (NICE, 2009).

There are many different approaches to offering support for parents of children with ADHD: for example, psychoeducation programmes (e.g. Montoya et al., 2011), information and advisory services (e.g. Hill & Taylor, 2001), academic skills programmes (e.g. Aram et al., 2010), family-centred support programmes (e.g. McIntyre & Hennessy, 2012) and parent stress-management training (e.g. Treacy et al., 2005). The positive effects of such programmes are noted, suggesting that they can lead to better relationships between parent and child and increases in parental knowledge about the condition (Montoya et al., 2011).

As Old Hill Special School could be considered a ‘good’ provision for pupils with behavioural, social and emotional needs (OFSTED, 2012) and as the school has a ‘higher than average’ number of pupils with a diagnosis of ADHD (OFSTED, 2012), I thought that it would be interesting to explore the provision that this setting offers for its pupils and consider whether this provision matches the recommendations from the literature. I also feel that many of the strategies recommended for pupils with ADHD would benefit other pupils with a profile of needs that could be categorized as behavioural, emotional and social difficulties.

Research questions

My initial interest, as well as the literature review, led to the development of three exploratory research questions:

- Is there evidence of support for pupils with ADHD within a BESD provision that matches identified ‘good practice’ from the research literature?
- Do staff working within a BESD provision view pupils with ADHD as having different needs from those without ADHD?
- What strategies and features of the classroom and the wider learning environment do staff consider important when supporting pupils with ADHD?

Original empirical work

Methodology

A case study methodology was adopted, as such an approach is ‘accessible, illuminating and reflects reality’ (p. 94, Wellington & Szczerbinski, 2007). Figure 1 (below) outlines the development of my case study, from identifying the purpose, through to the decisions made about what methods to use and the type of case study selected.

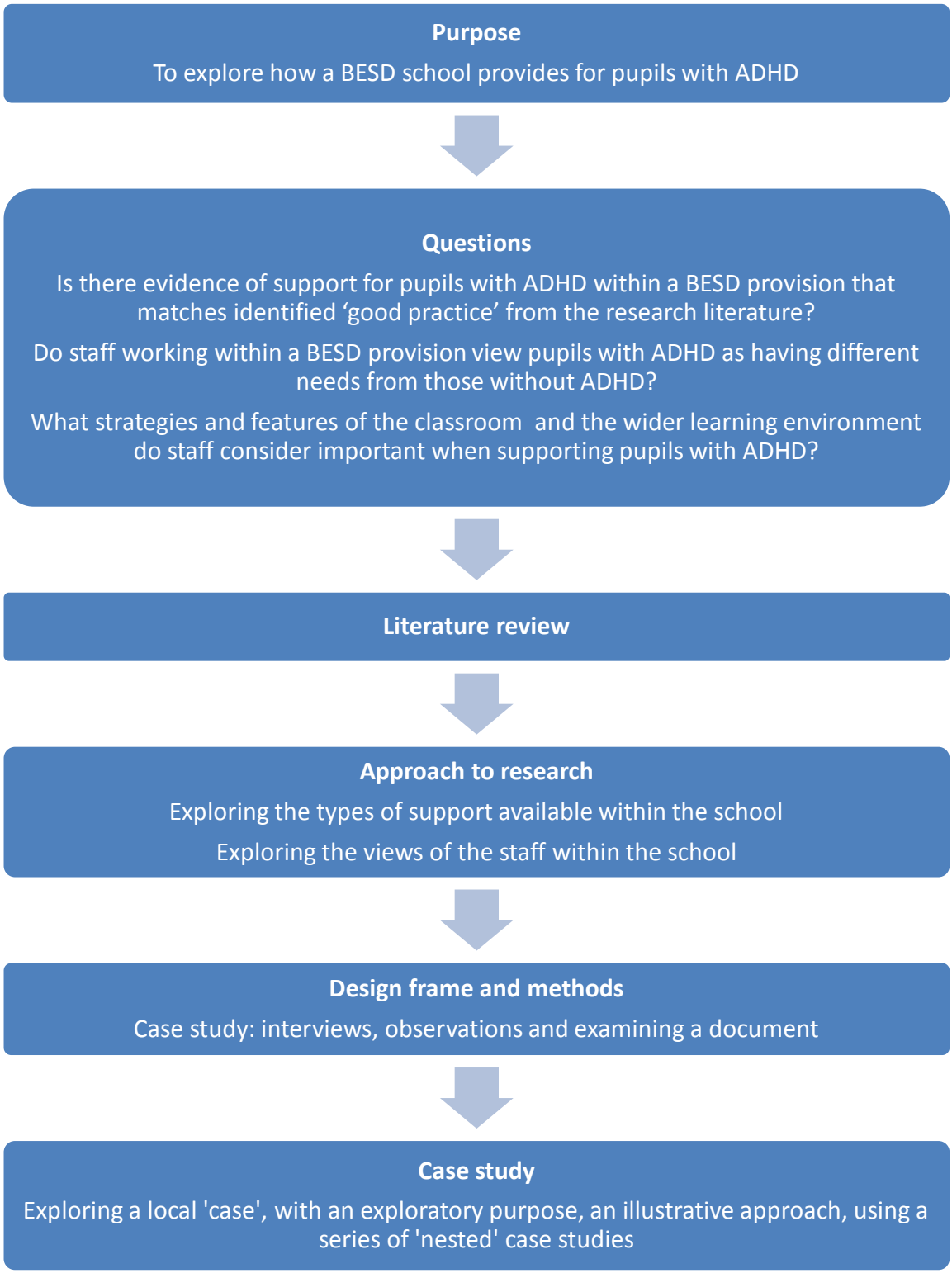

Figure 1 An illustration of my case study design (derived from Thomas, 2011)

Thomas (2011) highlights the importance of defining the 'type' of case study. My case study involved exploring a single local case, with an exploratory purpose, as I knew very little about the school and the provision offered to pupils with ADHD there prior to my research. This case study uses an illustrative approach, 'drawing a picture' (p.118, Thomas, 2011) of support within a BESD provision for pupils with ADHD. I used a series of 'nested case studies' as I carried out a number of observations of different lessons and a number of interviews with different members of staff within the 'case' (the school).

I will be taking a realist epistemological stance, as I am not seeking a 'universal truth' or interpreting our day-to-day experiences as 'social constructions'. Instead, I am aiming to look at the way in which our experiences (the empirical) depend upon the interaction between 'the real' and the actual (i.e. the context and environment). Of particular relevance to this study is the context in which the 'case' exists. In other words, it is important to view Old Hill Special School as an *example* of BESD provision catering for the needs of pupils with ADHD.

Methods

One of the benefits of using a case study design is that a number of different methods can be used to gather data. I decided to utilise a mixed methods approach, in order to gain a good 'picture' of the case being studied to be built up (Wellington & Szczerbinski, 2007). I used three different methods of data collection:

Structured observations

A structured observation is a 'method for systematically observing… in terms of a schedule of categories' (p.254, Bryman, 2008). This particular method of data collection was chosen as it allows behaviour to be directly observed (Bryman, 2008) and ensures that actual behaviour, rather than just stated behaviour, is examined.

Based on the literature, I developed a structured observation checklist (see Appendix 1). Bryman (2008) suggests that when developing an observation schedule, it is important to ensure that it will be easily operationalised. Therefore, my checklist simply involved a short description of the feature I expected to see, and a space for a tick if that feature was observed within the lesson. Another column was included to record comments, if necessary. It is important to note that the observation schedule I developed may have been interpreted differently by another observer. If another observer had been involved in this research, it would have been necessary to develop clearer guidelines regarding each feature.

I focused on the three areas from the literature review that could be observed within a classroom: the learning environment, behavioural interventions and monitoring behaviour. Similarly, I decided to use a checklist method of recording as this would be easy to operate within the classroom.

I carried out three thirty-minute observations, in three different lessons, with three different classes. Each lesson had either two or three pupils with a diagnosis of ADHD. These lessons were selected for me to observe by the Behaviour Intervention Leader in the school. I recorded on the observation checklist whether the feature described was present using a tick. For features that occurred on more than one occasion (e.g. focus on academic behaviour whilst ignoring other low-level behaviours), I gave a tick for each time I observed that feature.

Semi-structured interview

This particular method was chosen as I was interested in obtaining the interviewees' points-of-view regarding ADHD. A semi-structured approach was selected as a data-gathering tool due to its flexibility and the opportunity to ask follow-up questions, which other methods, such as questionnaires, would not allow (Bryman, 2008).

I developed a semi-structured interview schedule focusing on the seven key areas identified in my literature review (see Appendix 2). I began by identifying a key question relating to each of these areas and I also asked two initial questions regarding whether the interviewee had regular contact with pupils with a diagnosis of ADHD and whether they consider these children to have different needs from pupils without a diagnosis of ADHD. These two more 'closed' questions were included at the beginning of the interview schedule in order to put the interviewee at ease, before following up with the questions that were likely to require more thought and more complex answers (Wellington & Szczerbinski, 2007).

In order to gain a range of perspectives, I decided to interview three individuals, each of whom had a different role within the school:

- A senior teacher
- A teaching assistant
- The Behaviour Intervention Leader (whose role included delivering one-to-one interventions and offering behavioural support to pupils)

Before commencing the interview, I introduced myself and gave them a short explanation of the research and what I was investigating. This was done in order to build some level of rapport with the interviewee, as advised by Wellington and Szczerbinski (2007).

Using the interview schedule, these three members of staff were interviewed individually, with each interview lasting approximately twenty minutes. Their responses were recorded during the interview, through taking detailed notes and checking back to ensure that I had recorded their responses accurately.

Thematic analysis, ‘a method for identifying, analysing, and reporting patterns (themes) within the data’ (p.78, Braun & Clarke, 2006), was used to analyse the resulting interview data. Thematic analysis was selected as it is an accessible and flexible approach of data analysis; this appealed to me as I was relatively inexperienced with other methods of qualitative data analysis, such as grounded

theory, discourse analysis and so on. After familiarising myself with the data, initial codes were generated, followed by a process of searching, reviewing and defining themes, following the phases suggested by Braun & Clarke (2006).

Examination of school's behaviour policy

In order to gather more detailed information regarding the school's approach to behaviour management, I decided to examine the school's behaviour policy. This document is a statutory requirement of all maintained schools (Department for Education, 2012). The aim of the behaviour policy is to promote good behaviour within the school, prevent incidents of bullying, regulate the conduct of pupils and ensure work is completed (DfE, 2012). By examining Old Hill Special School's behaviour policy, I hoped to gain a more in-depth understanding of the systems and structures within the school that might support pupils with a diagnosis of ADHD. I focused on instances where behavioural interventions and behavioural monitoring were mentioned and conducted a brief content analysis. These were two key areas from the literature review that were considered important for pupils with ADHD.

Ethical considerations are presented in Appendix 3 of this report.

Findings

Is there evidence of support for pupils with ADHD within this setting that matches identified 'good practice' from the research literature?

Feature	Number of lessons the feature was evident in
Routine and structure to the day	2
Quiet area / Area for 'Time Out'	3
Pupils with ADHD placed away from distractions	2
Focus on academic behaviour whilst ignoring other low-level behaviours	3
Short reprimands when challenging behaviour does occur	3
Catch pupil being successful – use of immediate praise/positive comments for behaviour	3
Legitimate opportunities to move around the classroom	3
Reminders of appropriate behaviour and expectations	3
Evidence of encouraging self-monitoring of behaviour	2
Differentiation of task (e.g. answering verbally rather than providing written answers)	2
Instructions broken down into small chunks	3

Tasks broken down into small chunks	3
Use of physical cues to accompany instructions	3
Use of behaviour contracts	3
Use of individual targets	2
Use of short breaks/attention breaks during the lesson	3

Figure 2 Table highlighting key findings from the structured observations.

Three lessons were observed. All three lessons were taught by a different member of teaching staff, with two support staff, and a different group of children. One lesson had one pupil with a diagnosis of ADHD, while the other two lessons each had two pupils with a diagnosis. The pupils with a diagnosis of ADHD were pointed out to me by the teacher, so that I would be aware of where they were seated and the support that they were receiving.

Figure 2 shows that all of the features from the observation checklist (which were identified as good practice from the literature review) were evident in at least two of the three lessons observed. However, some of the features were operationalised in different ways. For example, pupils with ADHD in two of the lessons were placed

away from distractions. However, in one lesson the pupil with ADHD sat at the front of the classroom nearest the teacher with his peers behind him. In the other lesson where this feature was observed, the two pupils with ADHD were seated at the back of the classroom away from the potential distractions of their peers.

In all of the lessons observed, the teachers focused on academic behaviours whilst ignoring other low-level behaviours, made use of short reprimands when challenging behaviour occurred, caught their pupils being successful, allowed pupils legitimate opportunities to move around the classroom and reminded them of appropriate behaviour and expectations. Similarly, in all of the lessons observed both instructions and tasks were broken down into small chunks.

Individual targets were used in two of the lessons observed, and were displayed on the wall of the classroom or on the individual's desk. Pupils in all three lessons were given short attention breaks, with all teachers waiting until pupils were ready to begin the next activity and providing the pupils with a range of short activities.

The school's behaviour policy was examined and references to behavioural interventions and monitoring were noted (see Appendix 4). The key features from this brief content analysis were:

- The importance of consistency when supporting the behaviour of all pupils.
- Positive approaches to behaviour management, including rewards and consequences.
- A range of strategies, interventions and therapies for pupils with behavioural difficulties, with support from the Behaviour Intervention Team.
- The importance of looking at the individual needs of pupils when supporting their behaviour and setting individual targets.
- Pupils should be involved in recording, monitoring and evaluating their own behaviour.
- Staff training is important to meeting the needs of the pupils.
- Parents and carers should be involved in supporting positive behaviour.
- The development of social skills are important for pupils with behavioural difficulties.

It is important to note that there was no specific reference to pupils with ADHD within the behavioural policy, and this no specific interventions described that aimed to meet their needs.

Do staff working within a BESD provision view pupils with ADHD as having different needs from those without ADHD?

Thematic analysis (Braun & Clarke, 2006) of the three semi-structured interviews (see Appendix 5) suggested that the staff within Old Hill Special School had a variety of opinions with regards to pupils with ADHD having different needs from those without ADHD. One member of staff felt that the needs of pupils with ADHD were not that different from other pupils with BESD, although thought that these pupils' needs

varied depending on their academic ability or whether they had taken their medication. Two members of staff felt that pupils with ADHD did have different needs and required 'more intense or constant support'. The members of staff also raised concerns around appropriate diagnoses for their pupils and questioned whether their medication was of benefit.

What strategies and features of the classroom and the wider learning environment do staff consider important when supporting pupils with ADHD?

Development of the initial themes (from Figure 3 in Appendix 5) led to the identification of four main themes (see Figure 4 in Appendix 5) which the members of staff felt were important when supporting pupils with ADHD:

- Needs of pupils (as discussed above)
- Supportive adults (including the importance of staff and parents having sufficient training and/or information, good home-school links, time for the adults to reflect in parent groups or staff debriefing, training in appropriate interventions and regular reviews with staff and parents in the ADHD clinic)
- Interventions (including social skills support, consistent boundaries and expectations, behavioural support and monitoring, individualised strategies and extracurricular activities)
- Adaptations to the environment (including visual supports, seating arrangements, high adult:pupil ratio and a nurturing environment)

Discussion

The main findings suggest that support for pupils with ADHD within this setting does match the identified 'good practice' from the research literature. All of the features identified as 'good practice' within the observation checklist were observed in at least two of the three lessons observed. This suggests that within this particular BESD provision, the learning environment, the behavioural interventions implemented and the encouragement for pupils to monitor their own behaviour would suit pupils with a diagnosis of ADHD. These findings suggest that the school are aware of the potential benefits of making adaptations to the learning environment, such as those highlighted by DuPaul and Stoner (2003), Fabiano et al. (2009) and NICE (2009), and appear to be implementing them in their day-to-day practice. Similarly, the school's behaviour policy reflects elements from the research literature that are considered important for supporting pupils with ADHD, such as monitoring their behaviour, offering a range of behavioural interventions, the importance of staff training and the support of parents.

Some of the staff working within this setting view pupils with ADHD as having slightly different needs as those without ADHD. For example, two of the members of staff interviewed felt that pupils with ADHD require different levels of support, such as more constant monitoring or more 'allowances' made for them, such as time out from the classroom. However, all of the members of staff interviewed felt that their needs were similar to other pupils without a diagnosis but who still had a behavioural difficulty. This relates to the thoughts of Graham (2008) and Prosser (2008) who

both argue that the medical model (i.e. one where diagnoses and medication are key) is not particularly helpful for pupils with ADHD; instead, the focus for these pupils should be on helping them to manage their behaviour and taking a non-medical approach.

There are a number of different strategies and features of the classroom that staff considered to be important when supporting pupils with ADHD. These included the importance of the adults working with these pupils having sufficient information and training with regards to the condition. All of the staff reported that they had received some training on ADHD but that they felt that they would benefit from additional input. Of particular concern was the teacher's observation that she had received no input on ADHD during her initial teacher training; this is something that may be of relevance to the planning of future teacher training courses. This relates to the findings of Wheeler et al. (2008), who also found a lack of training for teaching staff regarding ADHD.

The staff reported that they felt it was important for them to have time to reflect on their support for pupils with ADHD during staff debriefing sessions and that it was also important for parents of pupils with ADHD to have the opportunity to share their experiences. This particular feature was not highlighted in the literature review, but the benefits of reflective practice in education are well documented (e.g. Belvis et al., 2013). This could be worth sharing with other schools, which perhaps do not provide these opportunities for reflection.

The school staff also noted a number of interventions and adaptations to the environment that they felt were key in supporting pupils with ADHD. These features reflected evidence from the research literature. However, one feature that was mentioned by all staff that was not frequently mentioned in the literature was the importance of a nurturing environment, with emphasis placed on the benefit of breakfast club, the 'family' lunch service where all pupils and staff eat together, extracurricular activities and short breaks. All of the staff felt that these helped the pupils with ADHD to improve their social skills, and may be worth considering in other schools with a high proportion of pupils with ADHD or other behavioural difficulties. Social skills interventions for pupils with ADHD are well documented in the literature (e.g. Borg, 2009; DuPaul et al., 2006). However, these studies advocate for direct teaching of social skills. The nurturing environment provided by the breakfast club, lunch service and activities at Old Hill Special School may provide an alternative approach to boosting social skills for those pupils with ADHD, due to the positive impact described by school staff.

Critique of methodology

Despite revealing some positive findings, consideration should be given to the limitations of the research methods used. It is important to note that the present research provides a case study example of provision for pupils with ADHD. It is possible that the findings from this case study may not be representative of other settings, and any conclusions drawn may relate solely to this particular school.

However, this case study still offers a valuable insight and rich picture of one setting (Thomas, 2011) and the way in which it provides for pupils with ADHD.

It could be argued that the observation checklist used was a rather subjective measure, with the 'features' not clearly defined and requiring some interpretation by the observer (Bryman, 2008). Therefore, an additional observer may have noted the presence or absence of these features in a different way. Ideally, it would have been useful to have a second observer to confirm the reliability of my observations. However, it could be argued that observations are more reliable than other data collection tools such as interviews (Bryman, 2008) as they are more likely to reflect what is actually happening in the 'real world'. Data gained from interviews may reflect what the interviewees *think* they ought to be doing or stating, but may not reflect actual practice.

It is important to note that the lessons which I observed were selected by the Behaviour Intervention Leader within the school, who was aware of the purpose of my research. As such, she may have specifically chosen lessons in which I would observe practices that reflected 'good practice' for pupils with ADHD. Similarly, the teachers that I observed had been aware that I was investigating provision for pupils with ADHD and so may have altered their own practice accordingly. For example, they may have purposefully asked the pupils with ADHD to sit in a different seat (either at the front or the back) than normal. As such, it is impossible to rule out the

potential impact of these biases, which may have been present whilst conducting my research.

It is also unclear how strictly the school staff adhere to the behaviour policy. The policy reflects many elements of good practice identified in the literature, but the only evidence as to whether staff follow this policy was collected during the observations or through interviews, where the interviewees may have given socially desirable answers. Elements such as the Personal Development Curriculum (e.g. breakfast club, family lunch service, out-of-school activities) were not observed. Future research could investigate these areas.

Another limitation with the research is that the interviews were not recorded and transcribed due to time constraints; during the interviews, contemporaneous field notes were made. This may mean that the researchers own biases and expectations may have influenced that data recorded (Bryman, 2008). However, answers to each question were relayed to the interviewee to confirm that I their views had been accurately recorded. This means that the data collected is still likely to be valid and reliable.

It is also important to note that only three members of staff were interviewed in this case study, and only three lesson observations were conducted. To gain a more reliable and valid picture of support for pupils with ADHD and the views of staff, it would have been beneficial to increase the size of the data set and interview a higher

number of staff members and carry out more observations in a wider variety of lessons and classes. This is something that could be done if the research were to be extended.

Future research

NICE (2009) highlight the importance of including parents and families of children with ADHD in any treatment. Data from the interviews with school staff suggested that they felt that this was important. However, I did not gain the views of parents in this case study. It could be that they would like opportunities to meet other parents who have children with ADHD, or perhaps receive additional information and support regarding the condition. If I were to extend this research, I would seek to gain the views of parents, perhaps by running a focus group to discuss the support they feel that they require.

It would also be interesting to gather the views of the pupils with ADHD to find out what type of support they feel is helpful. In particular, I would be interested in investigating whether they felt that social skills interventions (e.g. DuPaul et al., 2006) or self-monitoring of behaviour (e.g. DuPaul & Weyandt, 2006) affect their own behaviour. Similarly, an investigation of pupils' own views regarding the debate around ADHD and medication, such as that conducted by Bringewatt (2013), would also be of interest, particularly focusing on which discourses are prevalent in Old Hill Special School.

Future research could also look at carrying out a school-wide audit of levels of staff training, and offer targeted training on supporting pupils with ADHD to those who had not received this. The impact of this could then be measured, using pre- and post-intervention measures, and also looking at teachers' own views as to whether this training has influenced their practice in a positive way.

Conclusions

Case study research is often criticised for its lack of generalisability (Thomas, 2011). However, in this case it did offer a rich picture of the support available for pupils with ADHD within this particular setting, with the opportunity to gather evidence from a variety of sources using a variety of different methods (Thomas, 2011). The good practice noted within this setting could be shared with other schools of this type, as well as mainstream schools, to improve support for pupils with ADHD across the LA and nationally. This study also offered an insight into the views of school staff with regards to pupils with ADHD, suggesting that these pupils' needs are not seen as all that different from pupils with other BESD. This has implications for the support of all pupils with BESD, whose needs might be met by following the suggested strategies and interventions from the literature for pupils with ADHD. It also implies that the diagnosis is not the key issue; supporting the pupils' behavioural needs appears to be far more important than the medical label. This relates to Prior's (1997) notion that a holistic approach to identifying and supporting pupils with ADHD is of greatest benefit. In particular, the findings from this research suggest that it is important to

recognise the individual needs of pupils with ADHD, and therefore it is important to support them in an individualised way (Sava, 2000).

This has implications for all educational professionals, in particular EPs who can advocate for the child and support school staff and parents in meeting their needs without necessarily turning to healthcare professionals for medication. The role of the EP in supporting pupils with ADHD is not limited to their part in diagnosis and assessment, and instead may be more beneficial if the focus is on encouraging school staff to look to the research literature for non-medical strategies for support and intervention for pupils with ADHD in their classroom.

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Appendix 1: Observation checklist

(Focusing on: learning environment, behavioural interventions and monitoring behaviour)

Feature	Present?	Comment
Routine and structure to the day		
Quiet area / Area for 'Time Out'		
Pupils with ADHD placed away from distractions		
Focus on academic behaviour whilst ignoring other low-level behaviours		
Short reprimands when challenging behaviour does occur		
Catch pupil being successful – use of immediate praise/positive comments for behaviour		
Legitimate opportunities to move around the classroom		
Reminders of appropriate behaviour and expectations		
Evidence of encouraging self-monitoring of behaviour		
Differentiation of task (e.g. answering verbally rather than providing written answers)		
Instructions broken down into small chunks		
Tasks broken down into small chunks		

Use of physical cues to accompany instructions		
Use of behaviour contracts		
Use of individual targets		
Use of short breaks/attention breaks during the lesson		

Appendix 2: Semi-structured interview questions

1) Do you regularly teach/have contact with pupils with a diagnosis of ADHD?

2) Do you think that these children have different needs from other pupils within this school (who do not have a diagnosis)?

3) Have you received any training with regards to supporting students with ADHD?

4) What aspects of the learning environment do you consider to be important for students with ADHD?

5) What behavioural interventions for ADHD are implemented in school?

6) What methods for monitoring behaviour are in place in school?

7) What support (if any) is offered for helping students with ADHD to develop their social skills?

8) What individual support (if any) is available for students with ADHD?

9) What information/support is offered (if any) for parents of pupils with ADHD?

Appendix 3: Ethical considerations

Within this case study all participants rights and dignity will be respected, and it is unlikely that anybody will experience harm (BPS, 2010). However, a number of ethical considerations were raised:

Who benefits?

It is important to consider who benefits from any research (Bryman, 2008). With this particular case study, it was hoped that any information gathered would be of benefit to the school staff and the pupils; the data would hopefully highlight areas of strength within the school and areas for further development. In the unlikely event that any information gathered was of concern, this would need to be followed up with the Head Teacher of the school.

Confidentiality?

Confidentiality will be maintained in line with Section 5 of the BPS Code of Human Research Ethics (2010). All of the interviewees will be informed that their responses will be recorded anonymously and will not be linked to them.

Consent?

Consent needed to be obtained in line with Section 4 of the BPS (2010) Code of Human Research Ethics. All of the interviewees gave implied consent by agreeing to take part in the semi-structured interviews.

One potential area of concern was that the students did not consent to being observed. However, I was observing the classroom environment and the teacher's behaviour and verbal instructions, rather than observing the direct behaviour of the pupils. It is also likely that the pupils are used to visitors to the school (e.g. Educational Psychologists) and are used to being observed. Therefore, they were unlikely to have experienced any distress or discomfort from my presence in the classroom.

Feedback

Appropriate debriefing will be offered in line with Section 8 of the BPS (2010) Code of Human Research Ethics following each observation and each interview, if requested by the member of staff.

Appendix 4: Content analysis of behaviour policy

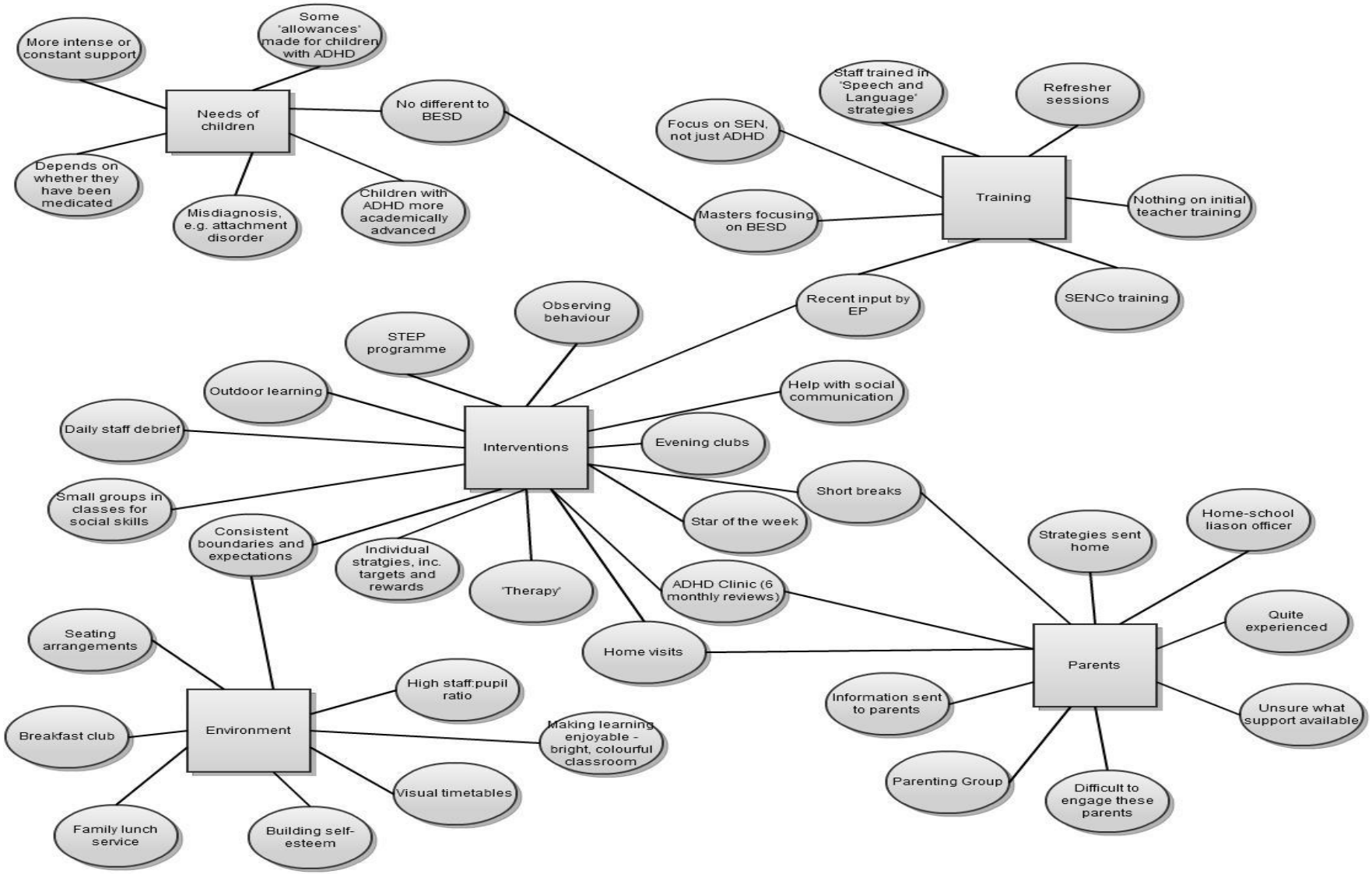
Examples of where behavioural interventions and monitoring are discussed in the school's behaviour policy:

- The policy is intended 'to be supportive, informative and bringing to the school **uniformity and consistency of action and response** in relation to the behaviour of staff and pupils.' (p.3)
- 'We have found that **positive approaches to behaviour management**, through **positive recognition and reward**, coupled with **clear and consistent systems and procedures for dealing with more challenging behaviour** is most effective. Creating and maintaining **an environment which is consistent, fair and predictable and where positive relationships develop** can best achieve this.' (p.4)
- '… **a range of strategies, therapies and interventions** will be needed to meet these needs and that one stand-alone method will not be sufficient.' (p.4-5)
- 'The school requires that all staff **take into account the individual needs and circumstances of a pupil** when applying the school's Promoting Positive Behaviour Policy.' (p.5)
- 'An **extensive and varied programme of training**, at both National and local levels, on specific behaviour and learning difficulties and remedial approaches will be offered to all staff on a regular basis.' (p.6)
- '**A system of rules, rewards and consequences**, based on Assertive Discipline, will be established.' (p.6)
- 'All pupils will receive **appropriate commendation and reward** for achieving against their **own personal targets** in learning and managing their own behaviour.' (p.6)
- **The STEP programme** (p.7) – rewarding pupils on a regular short- and medium-term basis, collecting data on behaviour of individuals and classes, **involving pupils in recording, monitoring and evaluating their own behaviour**.
- **The Personal Development Curriculum** (p.7) – breakfast club, break times, family service lunch, extended school activities, Second Step, Form Focus time, achievement activities and transport.
- **'Parents/carers** will be encouraged to be involved in all aspects of their child's behaviour at school…' (p.8)
- **A Behaviour Intervention Team** (p.8)
- 'The school will ensure that **all staff have training in the management and support of challenging behaviour**, including the use of verbal and non-

verbal de-escalation and communication approaches, conflict resolution strategies, self-protection strategies and restrictive physical interventions…' (p.9)

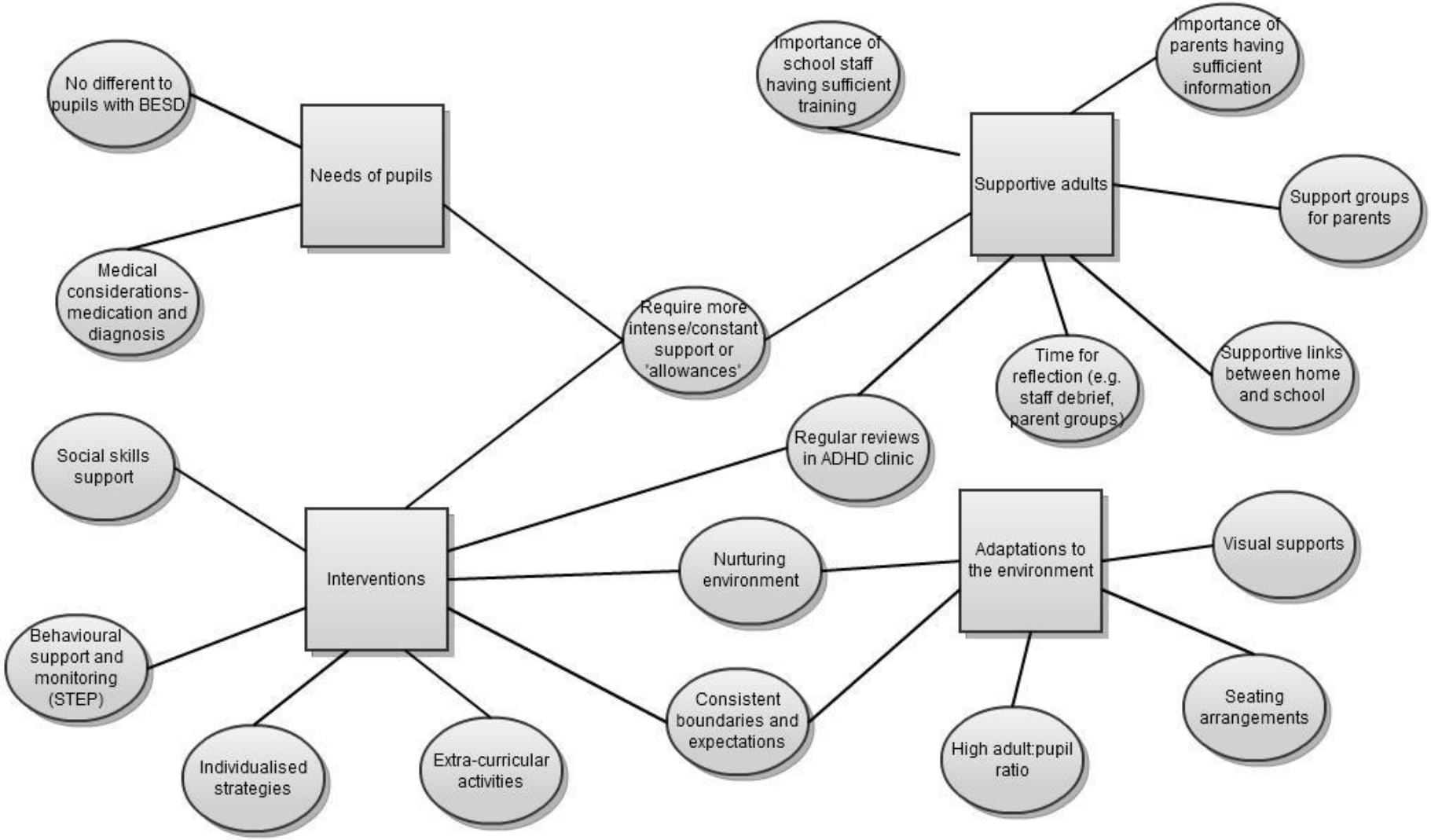
Appendix 5: Thematic analysis of interview data

Figure 3 Initial thematic map, showing five main themes



Appendix 5: Thematic analysis of interview data

Figure 4 Developed thematic map, showing four main themes



PPR 2: Is Brief Cognitive Behavioural Therapy (BCBT) an effective approach for helping children cope with separation anxiety? A case study example.

Abstract

Research has shown that anxiety disorders are the most prevalent mental health difficulty encountered by children. Using a case study example of a boy experiencing symptoms that could be associated with a clinical diagnosis of separation anxiety disorder (SAD), I aim to examine whether brief cognitive behavioural therapy (BCBT) is an effective approach for helping him cope with his difficulties. An initial literature review highlights key concepts regarding SAD and its diagnosis, the role of Educational Psychologists (EPs) in delivering therapeutic work and the effectiveness of CBT in treating anxiety disorders in children. My formulation and findings from the case study example are presented, followed by a discussion of these in relation to the relevant literature. Future areas for research and implications for EP practice are discussed.

Introduction

National context

Since the early 2000s, there has been increased interest in the emotional well-being of children, and the idea that mental health is 'everybody's business' (DfES, 2001). It has been estimated that 10-15% of children experience significant difficulties in their daily lives that would meet a clinical diagnosis of a mental disorder (DoH, 2004;

Squires & Dunsmuir, 2011). In addition to this 10-15% of children, it seems likely that there are many more that may be experiencing such difficulties, but who would not meet the criteria for a clinical diagnosis. The Department of Health (2004) suggest that around 40% of children who experience such difficulties do not receive any additional support. Reigada et al. (2008) also suggest that the majority of children with anxiety disorders do not access any professional services for help.

Alongside this growth in interest in emotional well-being and mental health is the idea that there has been 'a revival in the provision of psychological therapy' (p. 391, Pugh, 2010) amongst educational psychologists (EPs). As such, it would seem that the delivery of therapeutic interventions is one of the key roles of the EP. In fact, MacKay (2007) argues that there should be a 'rising commitment to therapy within the profession' (p. 7) due to this reported increase in mental health problems. Government publications, such as the Social and Emotional Aspects of Learning (SEAL) programme (DCSF, 2005), Targeted Mental Health in Schools (TaMHS) (DCSF, 2008) and the Improving Access to Psychological Therapies (IAPTs) initiative (DoH, 2008) have also led to an increase in focus on this area (Atkinson et al., 2011).

The recent publication of DSM-5 (APA, 2013) has led to changes in how some disorders, including separation anxiety disorder (SAD), are diagnosed. Bögels et al (2013) explain these changes; for example, DSM-5 allows adults to receive a diagnosis of SAD. Previous versions of the DSM only allowed a diagnosis of SAD if onset was before the age of 18 years, whereas research has illustrated that it is

prevalent amongst adults and has been under-diagnosed for this reason (Bögels et al., 2013). As such, SAD is a relevant area for investigation as it is likely that there will be an increase in interest in this disorder following these changes in the DSM-5 (APA, 2013). Similarly, Muris and Broeren (2009) argue that there has been consistently limited research specifically focusing on the treatment of SAD in childhood and that research has tended to focus on anxiety disorders in general.

It is important to note here that the DSM-5 (APA, 2013) diagnostic procedures and criteria have received intense criticism (e.g. Adam, 2013; Zur & Nordmarken, 2013). This will be expanded upon within the following literature review.

Local Context

As part of the thesis requirements for the Educational and Child Psychology doctoral training course, I was required to carry out and evaluate a therapeutic intervention. Within my Local Authority, EPs are allowed a high level of flexibility within their work. The absence of a 'time allocation model', which has been identified as a potential barrier to delivering therapeutic interventions (Squires & Dunsmuir, 2011) means that there were few barriers faced when I decided to undertake a piece of casework of this nature.

When I approached one of the primary schools in the area of the city which my Multi-Agency Support Team covers, the head teacher was able to identify a pupil whom

she felt would benefit from therapeutic support. During a consultation regarding this pupil, she described a highly anxious boy who was becoming distressed when he arrived at school. She reported that he found it difficult to leave his mother each morning, and worried that something would happen to her while he was at school. Further exploration of the views of the boy and his mother suggested that he might be experiencing separation anxiety. My formulation and details of this case are presented later.

As I was aware that Cognitive Behavioural Therapy (CBT) has been widely used to address anxiety disorders in children and has a strong evidence base (e.g. Barrett, 2000; Cartwright-Hatton et al., 2004), this was the approach that I decided to use. Atkinson et al. (2011) state that CBT is the most commonly used form of therapeutic intervention amongst EPs due to its 'emerging evidence base of its successful application' (p. 161) and the emphasis placed on this type of therapy in the postgraduate training courses for this profession.

It is important to note that I utilised a cognitive behavioural approach to intervention, rather than undertaking 'therapy'. This relates to Roth and Pilling (2007), who observed that there are a wide range of professionals, all of whom have received different levels of training, offering CBT. Roth and Pilling (2007) identified a set of competences, ranging from generic competences that relate to the delivery of any psychological therapy, to basic cognitive and behavioural therapy competences, to the more specific CBT techniques. Through self-assessment of my own

competences, I recognised that I have received training and am experienced in a number of these competences. However, I do not have a qualification in CBT, and therefore have limited experience in the latter set of these competences, namely the specific techniques employed by certified CBT therapists. However, this does not meant that I cannot use CBT techniques within an intervention (Roth & Pilling, 2007), but that it is important that I am aware of my own limitations and seek appropriate supervision relating to this therapeutic work. Therefore, the intervention outlined in this report utilises a 'cognitive behavioural approach', rather than strictly being classified as 'therapy'.

Literature review

My literature review was carried out using the University's online library 'Search' feature, looking for key terms such as 'separation anxiety' and 'cognitive behavioural therapy and children'. Articles from educational or psychological literature were of particular interest due to the focus of my work. However, articles from health and clinical research were also included; these appear to be the key areas where this particular difficulty, as well as type of therapy, is discussed in relation to children.

Separation Anxiety Disorder (SAD)

Anxiety disorders are reported to be the most common type of psychological difficulty experienced by children (Rockhill et al., 2010). Muris and Broeren (2009) conducted a review of studies focusing on childhood anxiety disorders published over the past

25 years, and found that there has been a rise in such publications in recent years, perhaps related to the increase in interest in the mental health of children alluded to earlier in this paper. The DSM-5 (APA, 2013) lists various phobias and anxiety disorders, including panic disorder, social anxiety disorder, selective mutism and separation anxiety disorder. The boy who will later be presented as a case study example did not have a clinical diagnosis of any disorder, but his presenting symptoms appeared to match those of SAD.

According to the DSM-5 (APA, 2013), SAD is characterised by 'developmentally inappropriate and excessive anxiety' relating to 'separation from home or from those to whom the individual is attached'. It also states that the disorder can cause 'clinically significant distress or impairment' in social or academic functioning (DSM-5, 2013). The DSM-5 (APA, 2013) lists symptoms that may be experienced by a child who has this disorder, including excessive distress, fearful thoughts that something bad will happen to them or their attachment figure, school refusal, reluctance to be alone, fear about sleeping away from their attachment figure, repeated nightmares and complaints of physical symptoms when separation from the attachment figure is anticipated. These diagnostic criteria offer an insight into the potential impact that SAD can have on a child's daily life, as well as the high level of worry and distress that may be experienced by their parents, friends, teachers, and so on. Diagnosis is made through structured interviews with the child and parent (Rockhill et al., 2010).

As mentioned previously, the DSM-5 (APA, 2013) diagnostic procedures have received criticism from a range of sources. For example, Adam (2013) has argued that mental health should be viewed as a 'spectrum', rather than being divided up into discrete diagnostic categories, particularly as there is little scientific evidence to support many of the 'disorders' outlined in the DSM-5 (APA, 2013) and the anecdotal evidence that many individuals do not fit 'neatly' into one particular set of diagnostic criteria. An even more contentious issue is the idea that the DSM-5 (APA, 2013) is published as a political or money-making tool for drug companies, and could be viewed as a method of social control (Zur & Nordmarken, 2013). Zur and Nordmarken (2013) argue that the DSM-5 (APA, 2013) pathologizes normal human behaviour; of particular pertinence here is the idea that anxiety can be normal and healthy, whereas the DSM-5 (APA, 2013) positions it as a mental illness that requires treatment. However, the DSM-5 (APA, 2013) is widely viewed as the standard method for diagnosing mental health conditions (Adam, 2013), and as such cannot be dismissed. It can be a helpful tool that can provide consistency in diagnosis and aid the development of evidence-based interventions (Moran, 2013).

Bekker and van Mens-Verhulst (2007) conducted a comprehensive literature search, and reported that, in adults, anxiety disorders appear to be more common in women than men. However, Allen et al. (2010) examined the frequency of symptoms in children of different ages and gender diagnosed with SAD. They reported that separation-related distress, avoidance of being alone and sleeping away from their attachment figure were the most common symptoms, and that there were no significant age or sex differences in terms of symptoms (Allen et al., 2010). It may be that women are more likely to meet

the criteria for SAD, but for children who have already received a diagnosis, there appears to be little difference in the way in which they experience the disorder.

Most children show distress from time to time when separating from their parents or caregivers. In fact, this type of behaviour is commonly seen in very young children (i.e. 9 months – 3 years) and is seen as part of 'normal development' (Vallance & Garralda, 2008). However, it is considered to be maladaptive if it continues after this age; if the distress is excessive and persistent, and leads to severe impairment, a clinical diagnosis may be necessary (Jurbergs & Ledley, 2005). SAD is estimated to be prevalent in 4-5% of children, who are often identified as needing support for their anxiety when they begin to refuse to attend school (Masi et al., 2001). When looking specifically at pre-adolescent children, some research has suggested that up to 41.2% of this population will experience SAD (Cartwright-Hatton et al., 2006). Therefore it would seem that SAD is a fairly common disorder, and it is likely that many children will experience it at some point throughout their childhood, even if only at a subclinical level (Jurbergs & Ledley, 2005). Research has also illustrated that the occurrence of SAD in childhood may be linked to an increased likelihood of experiencing later anxiety-related disorders in adulthood (Rockhill et al., 2010), and as such requires intervention.

The review conducted by Muris and Broeren (2009) suggested that there has been consistently limited research focusing specifically on SAD over the past twenty five years when compared to other anxiety disorders, such as post-traumatic stress

disorder (PTSD) and obsessive-compulsive disorder (OCD). As such, SAD is a relevant area for further study both due its reported prevalence and the potential impact that it may have on a child, adolescent or even adult's day-to-day life.

The aetiology of anxiety disorders has received much attention in research. Multiple explanations for anxiety disorders have been reported, including, but not limited to, genetic models, cognitive-behavioural models, physiological and environmental (Rockhill et al., 2010). SAD can be explained by a number of these models. For example, the cognitive-behavioural model suggests that the child experiencing the disorder has learned 'dysfunctional thoughts, feelings and behaviours through their experiences' (p. 68, Rockhill et al., 2010). These may then be reinforced as the child shows distress when separating from their parent or caregiver, who then may decide not to leave the child, thus allowing the child to 'escape' the situation that is perceived as threatening. Therefore, CBT may be a useful approach for supporting a child with SAD and reducing their symptoms, as it will attempt to change these dysfunctional thoughts, feelings and behaviours.

As an alternative explanation, Ginsburg et al. (2004) reported on findings that family behaviours may be linked to the aetiology of anxiety disorders in children. Both the temperament of the child and of the parent are reported to be associated with symptoms of anxiety, as are certain parental behaviours such as low warmth, hostility, rejection and over-control (Ginsburg et al., 2004). Patterns of attachment are also considered to play a potential role in whether a child will develop symptoms

of anxiety; for example, high levels of parental anxiety may lead to an insecure attachment relationship between the parent and child, which in turn may be linked to the child developing an anxiety disorder (Ginsburg et al., 2004). Other environmental influences are also proposed as possible causal factors of anxiety disorders in children, such as family discord, divorce and separation, and lack of a wider support network (Ginsburg et al., 2004).

It is important to note that much of the evidence discussed by Ginsburg et al. (2004) is based upon a range of parent and child self-report measures, which may be prone to bias (such as social desirability bias, (Bryman, 2008)), and thus their reliability and validity may be questionable. As such, evidence based on such measures must be treated with some caution. However, the majority of studies examined by Ginsburg et al. (2004) also use observational methods of data collection in conjunction with these self-report measures; these methods may also be open to biases, as they are based on the subjective views of the observer and only record observable behaviours noted at one point in time, often in an unnatural 'clinical' setting. However, this 'mixed methods' approach allows the researcher to triangulate their findings, and may offer increased validity (Bryman, 2008).

A final limitation with the studies examined by Ginsburg et al. (2004) is that few of them explored how familial characteristics related to a specific anxiety disorder. As such, it can be tentatively assumed that there is a link between these and anxiety disorders in general, but it cannot be concluded that a particular characteristic of the

parent, child or family leads to SAD, or social anxiety disorder, or selective mutism, and so on.

EPs delivering therapeutic interventions

As SAD appears to be a common disorder amongst children (with an estimated 41.2% of pre-adolescent children experiencing it (Cartwright-Hatton et al., 2006)) coupled with the severe impact that it seems to have on a sufferer's day-to-day life, it is highly likely that an EP will receive a referral from a concerned school or parent for a child with this type of difficulty at least once in their career. Due to their close working relationship with schools and families, EPs are well placed to offer support for these children through the use of therapeutic interventions without the need to access potentially stigmatising agencies such as Child and Adolescent Mental Health Services (CAMHS) or counselling (Atkinson et al., 2013a). Similarly, EPs may be able to address the shortfall in availability of CAMHS Services in delivering therapy (Stallard et al., 2007) and the 'fragmented and inadequate' provision available (p. 2, Atkinson et al., 2013b).

Therapeutic work is thought to be commonly used by EPs; Atkinson et al. (2012) found that around 92% of EPs responding to their questionnaire used therapeutic interventions with children as part of their practice. Similarly, Atkinson et al. (2013b) found the many EPs have 'significant' therapeutic skills (p. 8). Atkinson et al. (2013a) recently carried out a survey of EP Services in the UK that were offering therapeutic interventions to children as part of their practice; they aimed to investigate the factors

that ensured ‘effective provision of therapeutic interventions by EPs’ (p. 55). The key factors, identified through thematic analysis of interview data and service documents, that ensured therapeutic provision was effective included: promoting and contracting this type of work with schools, leadership commitment to therapeutic work, opportunities to practice, appropriate supervision, sufficient time and resources, and relevant training (Atkinson et al., 2013a). These findings reflect those presented by Squires and Dunsmuir (2011) who studied the facilitators and barriers in embedding therapeutic work for Trainee EPs.

It is important to note that Atkinson et al.’s articles (2011; 2012; 2013a; 2013b) are all based upon data initially collected as part of a UK-wide postal survey. Their online survey was advertised via ‘direct mailing to Educational Psychology Services (EPSs) in professional bulletins and electronic forums’ (p.22, Atkinson et al., 2012) and 455 individuals replied. These respondents self-selected, and as such may not be representative of the EP population within the UK. For example, the EPs who completed the survey may have been those who had a particular interest in therapeutic work; similarly, those who did not use therapeutic work within their practice may have felt that the survey was not relevant to them, and so chose not to complete the survey. Also, 455 respondents represents less than one fifth of all EPs working within the UK: there are currently around 2750 EPs registered with the Health and Care Professionals Council (HCPC) according to the DfE (2013). Atkinson et al. (2013) followed up their survey by visits to four EPSs. These Services were specifically selected for their interest and commitment to therapeutic work, and so again may not be representative of all EPSs across the country. Thus, the

findings indicating the high level of therapeutic skills, the high level of interest in this type of work, and the amount of this type of work that is being undertaken by EPs must be considered with caution.

Rait et al. (2010) suggest that since the increase of interest in promoting the emotional-wellbeing and emotional health of children, there has been an increase in EPs utilising therapeutic approaches in their work; therapeutic work is no longer viewed as solely the domain for CAMHS or clinical psychologists (Rait et al., 2010). This increase may also be linked to the insufficient therapeutic support currently available for children who are experiencing psychological difficulties (Suldo et al., 2010). This accumulation of evidence implies that EPs are well-positioned and have the relevant skills to be offering support to children who may be experiencing difficulties such as SAD.

Atkinson et al. (2012), following a UK-wide survey, reported that the most common therapeutic interventions utilised by EPs were solution-focused brief therapy, cognitive behavioural therapy, personal construct psychology, motivational interviewing and therapeutic stories. Pugh (2010) also suggests that EPs are becoming more frequently accustomed to delivering empirically supported therapeutic interventions, particularly using a cognitive behavioural approach.

Using CBT to treat childhood anxiety disorders

Children who experience any form of anxiety disorder are at risk of developing academic, social and family difficulties (Bernstein & Victor, 2007) and therefore effective treatment is crucial. The treatment of anxiety disorders in children has gained attention in recent years (e.g. Davis et al., 2011). Reynolds et al. (2012) conducted a meta-analysis of studies that used various forms of 'psychotherapy' to treat childhood anxiety disorders. They included fifty-five studies in their analysis, and found that the majority of studies evaluated the efficacy of cognitive behavioural therapy (Reynolds et al., 2012), suggesting that this form of therapy has been used more frequently than other forms when treating children with anxiety disorders. The studies which Reynolds et al. (2012) focused on were all 'high quality randomized control trials' (p. 251). Randomized control trials are considered to be the most 'powerful' method of data collection in terms of reliability and validity of findings (Bryman, 2008). From their findings, Reynolds et al. (2012) concluded that anxiety disorders in children can be treated effectively, particularly when CBT approaches are used.

Pugh (2010) describes cognitive behavioural therapy as a multi-component process, which may include elements of psycho-education, symptom management, cognitive restructuring, problem solving, exposure and relapse prevention. CBT is based on the idea that people experience mental health difficulties, such as anxiety, when they are 'locked into unhelpful patterns' (p. 17) of thought (Dudley & Kuyken, 2006). The aim of CBT is to change these unhelpful patterns of thought and learn more helpful

ways of thinking, which will then influence the individual's feelings and their behaviour.

Cartwright-Hatton et al. (2004) conducted a systematic review of treatment for childhood anxiety disorders. This approach allows the findings from several studies, which may have had small sample sizes, to be 'pooled' together, allowing the 'power and precision of effect size estimates to be increased' (p. 422, Cartwright-Hatton et al., (2004)). This study identified Kendall (1994) as the first published randomized clinical trial where Cognitive Behavioural Therapy (CBT) was used to treat young people aged 9-13 years who were presenting with an anxiety disorder. Encouraging findings were reported (Kendall, 1994), and since then a number of other studies have shown positive outcomes following the use of CBT to treat anxiety disorders (Cartwright-Hatton et al., 2004). In the case study presented below, the boy was experiencing symptoms that could be associated with SAD. It is important to note that although Cartwright-Hatton et al. (2004) highlight the effectiveness of CBT for treating childhood anxiety disorders, they do not offer specific information regarding the effectiveness of treating SAD with CBT.

Davis et al. (2011) reviewed evidence-based treatment by dividing the different anxiety disorders into separate categories, and again noted that CBT has consistently been shown to be effective in treating a range of childhood anxiety disorders. However, they note that 'the vast majority of trials exploring treatments for childhood anxiety do so by grouping several anxiety diagnoses together rather than

studying them individually' (p. 598, Davis et al., 2011). This means that although CBT has been shown to be effective for treating childhood anxiety disorders in general, we can only tentatively state that CBT is effective for treating SAD specifically. However, it is likely to have a positive impact as all childhood anxiety disorders share 'a common underlying anxiety construct' (p. 192, Bernstein & Victor, 2007).

If we are to assume that CBT is an effective way of treating SAD, it is important to pay attention to the research that positions CBT as an effective approach. Barrett (2000) argues that CBT is an effective approach to treating anxiety disorders in children, but that treatment should be designed from a 'child-based perspective' (p.479) instead of based on adult models of treatment on which this approach was founded. In line with this recommendation and the increasing interest in therapeutic interventions, there have been a number of books published which provide materials and information on delivering CBT with children (e.g. Stallard, 2002; Plummer, 2010). Another developmental consideration highlighted by Barrett (2000) when planning to deliver a CBT intervention is the age of the child; she argues that primary school-aged children are at the optimal age for treatment due to their openness to ideas, the ease of gaining support from their parents and the wider community, and the fact that children of this age are easily accessible through school.

However, it is unclear whether children can give informed consent to take part in a therapeutic intervention, such as CBT. NICE (2009) suggest that children and young

people under the age of sixteen can only consent to treatment if there are deemed 'Gillick competent'. This refers to the idea that children may have enough understanding of what the intervention involves before the age of sixteen and can then decide whether to consent or not. Similarly, consent is only valid if it is given voluntarily (NICE, 2009); if parents or other adults exert pressure upon the child to give consent, then this is invalid. If a child is deemed not 'Gillick competent', then a parent can give consent on their behalf. This is a challenging area for therapeutic practitioners, as it is often unclear whether a child has given voluntary, informed consent, or whether they are competent to do so.

The importance of gaining support from parents or carers when delivering CBT interventions has also received attention in the research literature. Ginsburg et al. (2004) summarised findings from a range of studies that had included parents, as well as their children, in CBT interventions for childhood anxiety disorders; they found improved outcomes for those children whose parents had been involved alongside their treatment when compared with children who had received only individual treatment. Waters et al. (2009) reported similar findings, noting that parental treatment in conjunction with child treatment (both using CBT) led to over half of the children no longer meeting the clinical criteria for a diagnosis of an anxiety disorder after ten weeks, and also at six-month and twelve-month follow-up.

Bernstein and Victor (2007) also highlight the efficacy of CBT as a treatment for childhood anxiety disorders. However, they argue that combining this form of

treatment with medication (namely a type of antidepressant known as serotonin-reuptake inhibitors) is the most effective treatment (Bernstein & Victor, 2007). However, due to potential side effects (such as an increase in suicidal ideation), CBT alone is argued to be the most effective treatment approach when the child is experiencing only mild to moderate symptoms (Bernstein & Victor, 2007). Related to this is the study carried out by Brown et al. (2007), who found that parents of children with an anxiety disorder found CBT to be a more acceptable form of treatment and also felt that it was more effective than other forms of treatment, including medication.

The majority of studies evaluating the efficacy of CBT as a treatment for childhood anxiety disorders have focused on individual interventions, rather than universal or group approaches. However, Essau et al. (2012) evaluated a universal, school-based, preventative CBT programme known as 'FRIENDS'. Their study found evidence that taking such an approach can reduce symptoms of anxiety and depression amongst children who are considered part of the 'normal' population, and not just in those from a clinical population (Essau et al., 2012). Lau et al. (2010) evaluated a group CBT approach and found a reduction in anxiety and improvements in the children's ability to cope with anxiety-provoking situations. These two studies were conducted in Germany and Hong Kong respectively, which means that their findings must be generalised to the UK with caution, as there may be cultural and educational factors that differ between the school-aged populations in these countries.

Intervention planning

Crawley et al. (2013) recognised the benefits of using CBT with children with anxiety disorders, but also noted that it can be more time- and cost-effective to implement Brief Cognitive Behaviour Therapy (BCBT), as it requires fewer sessions. This may make it more appealing to potential 'clients', as it would require less time, effort and cost than completing a lengthy programme of CBT (Crawley et al., 2013). BCBT follows the same principles as CBT, but reduces the number of sessions (i.e. fewer than 10, instead of 10-20) by focusing on restructuring only the key thought distortions (determined by the therapist), rather than attempting to address all of them (Culley & Teten, 2008).

Research question

The literature review, along with the requirement of my thesis to carry out and evaluate the impact of a therapeutic intervention, led to the development of the following research question:

- In a case study example, does BCBT appear to be an effective approach for helping children cope with separation anxiety?

Case Study

To investigate the efficacy of BCBT as a treatment approach for helping children cope with the symptoms of separation anxiety, I decided to use an illustrative case study (Thomas, 2011) with a positivist approach, aiming to discover an external and objective reality, using quantitative data to evaluate the intervention. A positivist approach has been selected, due to my belief that knowledge can be gained from verifying observable experiences through the use of data-gathering tools, such as quantitative questionnaires and surveys. This approach also allows for cause-and-effect relationships to be established, such as the link between a BCBT intervention and a reduction in symptoms of anxiety.

Case study example: John

John is a nine-year-old boy attending a mainstream primary school. He lives with his mother and elder brother, who is seventeen. John was referred to the Educational Psychology Service by the head teacher of his school, with the consent of his mother, due to concerns around his anxiety and emotional needs. The pre-intervention assessment involved a meeting with the head teacher of John's primary school, a meeting with his mother, and a meeting with John himself. Allen et al. (2010) suggest that it is important to gain the views of multiple informants when gathering information about the presenting problem. Also, a thorough assessment at the initial stages aids with intervention planning and allows for evaluation of impact post-intervention (Bernstein & Victor, 2007).

Although John had been seen by his local CAMHS, he had not received a diagnosis of SAD when I began working with him. However, it was agreed that his pattern of symptoms were similar to the diagnostic criteria identified by DSM-5 (APA, 2013) for SAD. The CAMHS worker that had met with John and his mother had discussed using a CBT intervention to reduce these symptoms, but had not initiated this work as John's mother had informed him that I had planned a similar intervention.

The head teacher, John and his mother were asked to complete the relevant Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997). The SDQ (Goodman, 1997) is a self-report questionnaire which looks at a child's strengths as well as their difficulties, in terms of their behaviours, relationships and emotions; the child, parent, or teacher is asked to indicate whether each of twenty-five statements applies to them or the child and indicate what impact the difficulties are having on their own or the child's life. It has been widely used in research since its development and research has shown that it is a valid predictor of child mental health difficulties within Britain (Goodman & Goodman, 2011). John and his mother were also asked to complete the Revised Child Anxiety and Depression Scale (R-CADS) and the parental version (RCADS-P) respectively (Chorpita et al., 2000). This is a self-report measure, where the child or parent indicates whether each of the forty-seven items relates to them or their child ('never', 'sometimes', 'often' or 'always'). This scale was chosen as it relates directly to the dimensions of anxiety presented in the DSM (Chorpita et al., 2000). These measures were repeated post-intervention.

Using the information gained from these discussions, along with the two measures, the following formulation (see Figure 1) was developed in collaboration with John, his mother and school staff:

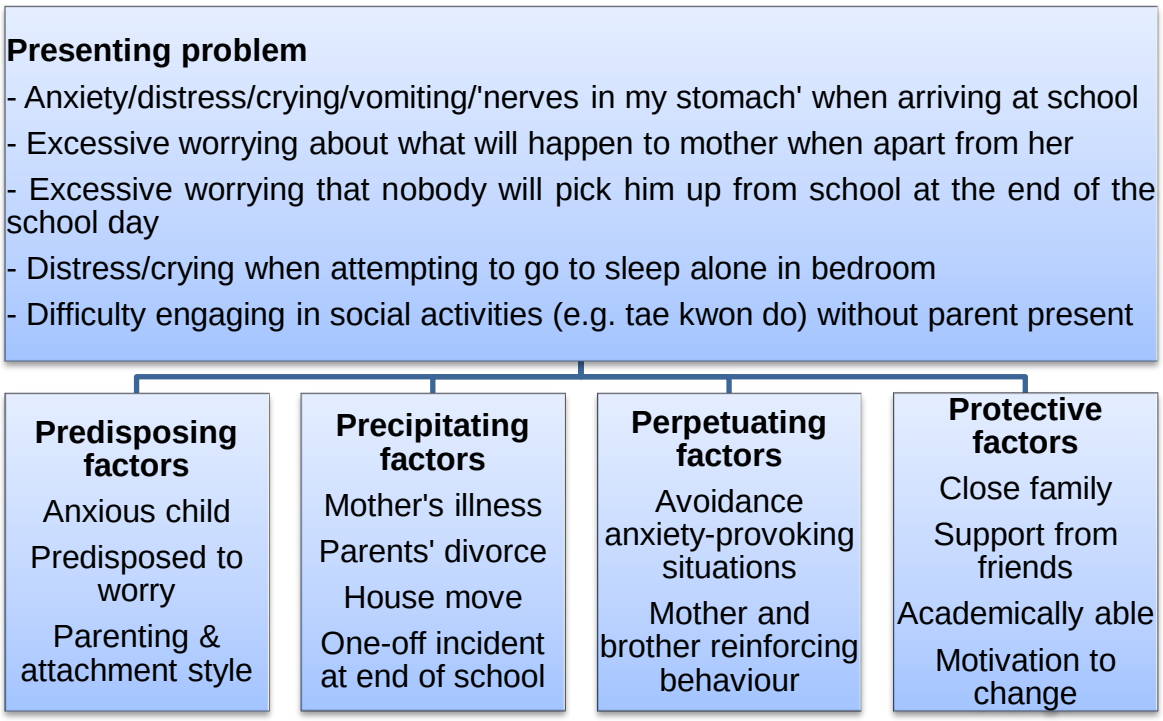


Figure 1: CBT formulation (based on Johnstone & Dallos, 2006) and aetiological factors identified by Fong & Garralda (2005) and Jurbergs & Ledley (2005)

This formulation suggested that John was experiencing anxiety and worries above and beyond what would be expected for a child of his age. Due to time constraints and caseload commitments as a Trainee EP, BCBT appeared to be a therapeutic approach that could be implemented easily within a school setting. Hence, in the present case study, a 7-session BCBT intervention was designed and implemented

with John, with the support of his mother (see Appendix 1 for a more detailed overview of sessions).

During the first session, I gathered more information from both John and his mother in order to develop my formulation. Based upon this formulation, I was then able to plan the following sessions using materials from 'Think Good – Feel Good' (Stallard, 2002). These materials were selected as they were thought to be age appropriate for John and provided structured activities on which to base my sessions whilst working within a CBT framework. This book does not provide a 'step-by-step' approach to CBT, which meant that I was able to choose freely the activities or sections from the book which reflected the aspects of CBT that I wished to focus on in that particular session. I took a flexible approach to each session, meaning that if John wished to discuss something in more depth than I had planned, I allowed time for this and on one occasion moved part of one session into the next session.

John's mother was included in the intervention, as it was felt that some of her behaviours were reinforcing John's anxiety; for example, she would stay with him until he fell asleep at bedtime, and would allow him to 'opt out' of social activities that he would enjoy, just so as to avoid outbursts of crying and anxiety. Research findings have shown that involving parents in the intervention can have a positive impact on outcomes (e.g. Silk et al., 2013).

The aim of the BCBT programme was to target John's unhelpful thoughts and help him develop more adaptive ways of thinking. By changing John's thoughts, I hope to alter the way he felt during potentially anxiety-provoking situations and thus influence his behaviour. Figure 2 illustrates John's maintenance cycle of thoughts, feelings and behaviour (Simmons & Griffiths, 2002). These were elicited through discussion with John.

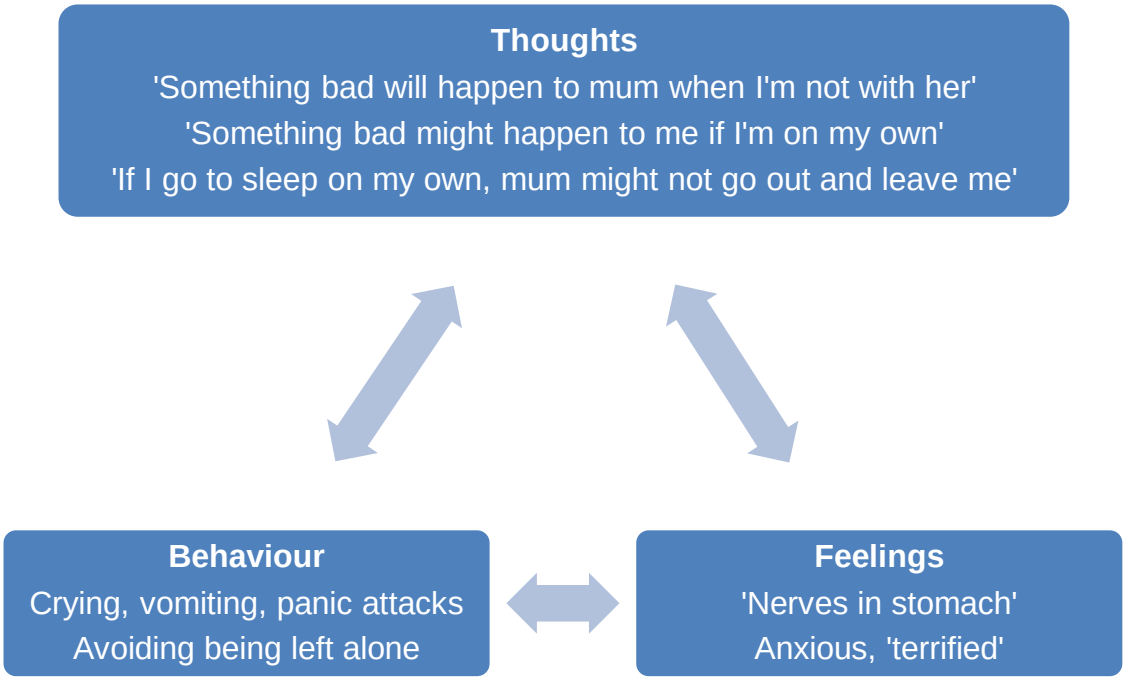


Figure 2: Maintenance cycle for John

This negative cycle suggested that in order to change John's feelings and behaviour regarding the situations he found distressing (e.g. arriving at school, separating from his mother, going to bed alone), the way he thought about these needed to be altered. This was the main focus of my BCBT intervention.

Findings

The findings from the pre- and post-intervention measures completed are presented below.

	Child		**Parent**		**Teacher**	
	Pre	Post	Pre	Post	Pre	Post
Overall stress	6	8	11	11	13	6
Emotional distress	2	4	6	4	8	4
Behavioural difficulties	2	1	2	1	0	0
Hyperactivity & attentional difficulties	0	1	3	4	5	1
Social difficulties	2	2	0	2	0	1
Kind and helpful behaviour	8	9	8	9	N/A	9
Impact of difficulties on child's life	0	0	1	0	2	0

Figure 3: Pre- and post-intervention scores for the SDQ (Goodman, 1997). Scoring: To indicate a 'clinically significant problem', a child must score above 13 for overall stress, above 4 for emotional stress, above 3 for behavioural difficulties, above 6 for hyperactivity, above 3 for social difficulties, or below 5 for kind and helpful behaviour. In the last row, a score of 2 or above suggests that the child's difficulties are having a significant impact on their life. N/A indicates that a score could not be calculated due to missing data.

For both parent and teacher reports, Figure 3 shows that for the majority of areas of difficulty, there was a reduction in difficulty score at post-intervention. John's mother indicated a slightly higher score for 'hyperactivity and attentional difficulties' and 'kind and helpful behaviour'. From Figure 3, it can be seen that John's self-report scores

actually increased post-intervention. Possible explanations for this will be discussed below.

Overall, scores from the SDQ (Goodman, 1997) indicate mixed results. The teacher's reports suggest a reduction in overall stress following intervention, whilst the parent's reports suggest no change overall. In contrast, John's self-report suggests that his difficulties may have increased following the intervention.

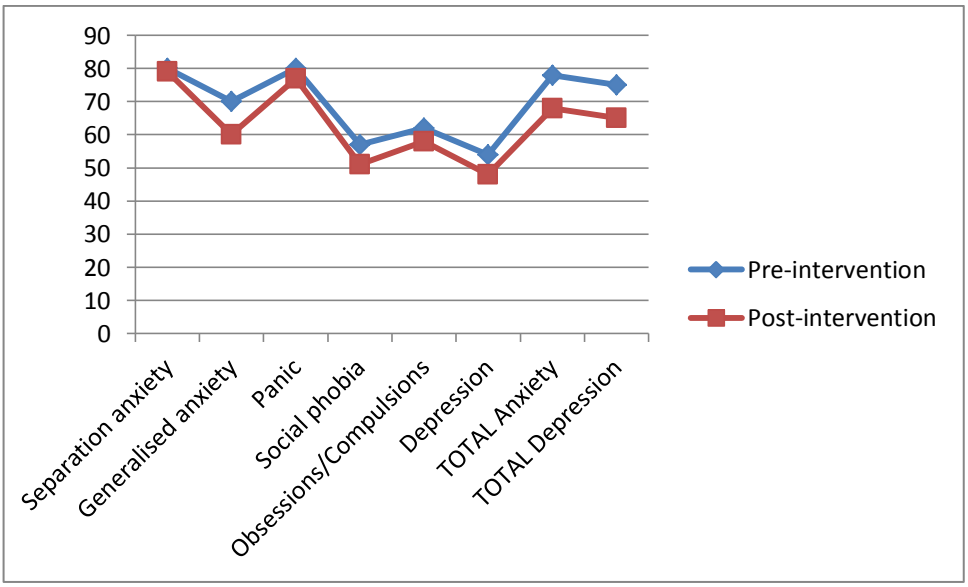


Figure 4: Graph to show RCADS-P (Chorpita et al., 2000) scores. Scoring: a T-score of 65 or above may indicate a clinically significant difficulty.

Figure 4 illustrates the pre- and post-intervention scores from the RCADS-P completed by John's mother. This suggests that, in general, there was a reduction in total anxiety and total depression following intervention. Scores for the all of types of anxiety also reduced post-intervention, to differing degrees.

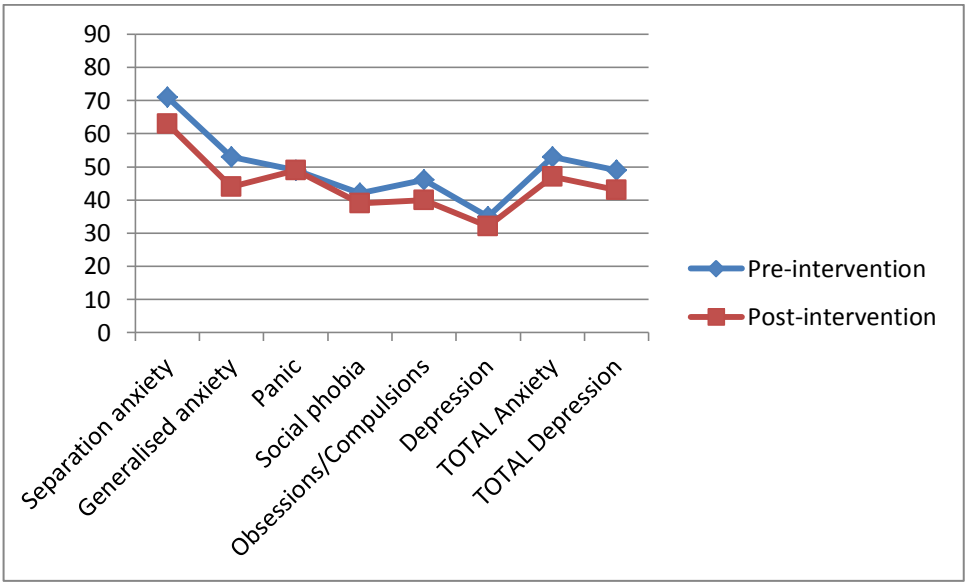


Figure 5: Graph to show RCADS (Chorpita et al., 2000) scores. Scoring: as above.

Figure 5 shows the RCADS scores completed by John pre- and post-intervention. This indicates that total anxiety and total depression scores fell after the intervention, and that scores for all types of anxiety fell, apart from 'panic' which remained the same.

Discussion

The findings from this case study, highlighted above, suggest that BCBT may be an effective approach for helping reduce the symptoms of anxiety (measured using the RCADS (Chorpita et al., 2000), pre-and post-intervention, completed by child and parent). These self-report measures indicate that the BCBT intervention led to a reduction in reported 'total anxiety' and 'total depression' scores, as well as reductions in all identified types of anxiety, including separation anxiety.

Scores from the SDQ (Goodman, 1997) completed by child, parent and teacher, were more mixed. The teacher's report indicated that the intervention had had a positive impact in reducing the child's difficulties. However, the parent's report suggested some reduction in difficulties in areas such as emotional distress and behavioural difficulties, but no change in overall stress. The child's own report actually indicated an increase in overall stress post-intervention. These scores might lead one to conclude that BCBT has little impact on a child's difficulties. However, there may be an explanation for these findings. John's scores on the SDQ (Goodman, 1997) actually increased across all areas post-intervention; this could be because, through intervention, he had the opportunity to discuss and think about the difficulties that he was experiencing, thus making him more aware of them. His responses to the questionnaire pre-intervention were notably different from both his parent and teacher, in that he did not note that his difficulties were having a significant impact on his life and that he was only affected by his anxiety 'sometimes' (rather than 'often' or 'always'). This suggestion may be corroborated by John's scores on the RCADS, which were notably lower than his mother's pre-intervention.

When considering the effectiveness of an intervention, it may also be useful to reflect on the anecdotal evidence relating to the effectiveness of the intervention, such as the responses of the individual. John reported that he enjoyed our sessions and felt that they were helpful with managing his anxiety. He appeared to become more confident in talking about his difficulties as each session progressed and became more successful at identifying his 'unhelpful thoughts' and replacing them with 'helpful' ones. Both John and his mother also noted a difference in John's attitude

towards school and informed me that by the end of our last session, he rarely cried when arriving at school. Prior to the intervention, John reported that he had cried when arriving at school, on average, four times per week. Although this evidence is anecdotal and does not prove the effectiveness of the intervention, it does highlight some of the important changes that both John and his mother noted following the intervention. This information is not captured in the measures used.

Overall, it is difficult to conclude that BCBT is an effective approach at helping children deal with the symptoms of separation anxiety, as findings were mixed. Similarly, the RCADS (Chorpita et al., 2000) indicated that BCBT helped reduce overall stress and scores for different types of anxiety, but not the score for separation anxiety alone. Therefore, it is best to conclude that BCBT is an effective approach at helping children deal with the symptoms associated with anxiety disorders in general, which may lead to a reduction in symptoms associated with SAD.

Importantly, caution must also be taken when drawing conclusions from the present case study example, as there was no control case. Thus, it is possible that the changes seen post-intervention may have occurred due to factors other than the intervention. For example, environmental changes, changes in the relationship between child and parent, the child's own resiliency increasing due to external factors, and so on.

Although the BCBT intervention may have helped reduce anxiety symptoms in the present case study, it has not eradicated all symptoms. John was reported to still be experiencing some anxiety symptoms, particularly those related to going to sleep on his own. Follow-up sessions have been offered to John and his mother, in which it would be hoped that his symptoms will reduce further. However, as Cartwright-Hatton et al. (2004) indicate, despite receiving a CBT intervention, between 20 and 60% of children would still meet the criteria for a clinical diagnosis of an anxiety disorder. Liber et al. (2010) suggest that this may be due to what they term the 'child-therapist alliance' (p. 173); in order to achieve the positive impact that studies, such as those included in Reynolds et al. (2012) meta-analysis, the therapist must develop a strong bond, or alliance, with the child. In the present case study, it should be noted that the therapist only had eight sessions in which to develop this. Perhaps one of the benefits of traditional CBT is its length: the higher number of sessions, when compared to BCBT, would allow the therapist to build a stronger relationship with the child.

Another area which may have impacted on the outcomes of the BCBT intervention in the present study is parental involvement. Although John's mother was involved in the intervention, this was mainly in a two-way information-sharing role, where she provided additional information to the therapist and vice versa. She was encouraged to ensure that John was gradually exposed to anxiety-provoking situations, but perhaps outcomes would have been more notable if she had taken on another role. For example, Silk et al. (2013) found CBT to be most beneficial when parents actively encouraged bravery in their anxious children. Similarly, Waters et al. (2009), as

mentioned previously, noted beneficial effects when parents received CBT at the same time as their child, perhaps due to the impact that parent-child interactions can have on the maintenance of anxiety symptoms (Fong & Garralda, 2005).

Related to this is the fact that John's father was not involved in the intervention in any way. Bögels and Phares (2008) note that the role of fathers has often been neglected in research into anxiety disorders in children, both in terms of aetiology and treatment outcomes. Research has shown that a child is at risk of experiencing anxiety symptoms if their father is not involved and does not encourage independence (Bögels & Phares, 2008). Fathers' functioning and own experiences of anxiety are also linked to treatment outcomes. Perhaps if John's father had been involved in both the planning intervention process, outcomes would have been more positive.

Another explanation for the current findings that relate to the review by Bekker and van Mens-Verhulst (2007) who identified gender differences in prevalence and underlying issues surrounding anxiety disorders in adults, but noted that treatment is often gender-neutral. Treatment, including CBT or BCBT, may be more effective if gender is taken into consideration when planning the intervention.

Jurbergs and Ledley (2005) emphasise the importance of exposure (where the young person is purposefully 'exposed' to the anxiety-provoking situation) as part of the

CBT process for treating SAD. In the present case study, exposure was included as part of the intervention plan. However, this exposure was only related to one of John's anxiety-provoking situations: arriving at school and separating from his mother. This was presented as the most challenging aspect of John's anxiety, and the one which both parent and teacher wanted John to receive support for. This meant that one of John's other key worries (going to bed alone) was not the focus of the BCBT intervention. As such, this behaviour has continued with little noticeable improvement in symptoms, hence the mixed findings from the post-intervention measures. The planned follow-up sessions are likely to focus on this particular worry.

A methodological issue that is important to consider is the limitations of self-report measure; these measures are open to biases, such as social desirability bias – where the individual feels under pressure to give socially desirable answers, and demand characteristics – where the individual gives the answers that they suspect the researcher wants to hear (Bryman, 2008). These potential biases mean that any findings must be interpreted with caution. Another potential limitation of the present study is the fact that it is based on only one case study example. In order to draw stronger conclusions regarding the efficacy of BCBT, it would be beneficial to use the same intervention with a larger sample of individuals.

When deciding on the best intervention for helping children manage the symptoms of separation anxiety, it is important to consider alternatives to BCBT. For example,

Fong and Garralda (2005) highlight such alternatives: psychodynamic psychotherapy, dynamic therapy, family therapy and pharmacotherapy. Many studies also highlight the benefits of combining CBT with medication (e.g. Bernstein & Victor, 2007; Walkup et al., 2008). Therefore, future research could focus on evaluating and comparing the outcomes for children with SAD. This is especially pertinent as Muris and Broeren (2009) highlight the lack of research focusing specifically on the treatment of this disorder, particularly for pre-adolescent children (Cartwright-Hatton et al., 2004). Another avenue worth considering is the use of CBT as a universal programme for all children, delivered in schools; Essau et al. (2012) found significant benefits of such an approach, including a reduction in symptoms of anxiety that continued at six- and twelve-month follow-up. Future research could include further long-term measures of the efficacy of different treatment approaches, along with an exploration of why some children respond to psychological therapy, while others do not (Kendall et al., 2012).

Conclusions

In conclusion, this case study suggests that BCBT may be an effective approach for helping children cope with separation anxiety, particularly when parental and school staff self-report measures are taken into account. However, child self-report measures revealed mixed findings. Potential limitations (discussed above), along with the Trainee EPs limited experience in delivering this type of intervention must be taken into account when interpreting these results. However, the moderately positive outcomes suggest that this approach to intervention may be beneficial.

The present findings have implications for the future of educational psychology. For example, if EPs are to be involved in this type of intervention, high levels of training in such approaches should be ensured, particularly in light of changes to the profession, including the increase in the number of traded EP services (Pugh, 2010), where payment by outcomes may not be too distant. Similarly, the capacity of EPs to deliver these potentially time-consuming interventions whilst battling with competing demands requires further thought (Atkinson et al., 2011), especially as services may reduce to council budget cuts (Atkinson et al., 2012). Field et al. (2008) suggest that further investigation of the role of parents in the development of anxiety-related symptoms is crucial; therefore, further research focusing on the outcomes of EPs working therapeutically with parents, alongside their children, might lead to interesting results. Identifying those children most at risk of developing anxiety disorders is also an important area for further investigation (Norton & Asmundson, 2000), and EPs may be well-placed to support schools with this.

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Appendix 1: Overview of sessions

My BCBT intervention was based on plans for similar interventions from a range of sources including Dia (2001), Reigada et al. (2008) and Beidas et al. (2013). I also used materials from Stallard (2002) and Plummer (2010).

Seven sessions were planned, as these sessions fell within the school term dates. Follow-up sessions have been planned for the following term (September 2013). The following information summarises what was covered in each session:

Session 1

Child (45 mins)	Parent (45 mins)
• Introductions • Discussion of confidentiality • Rapport building • Explaining BCBT • Normalizing anxiety • Introducing link between thoughts, feelings and behaviour (The Magic Circle – Stallard (2002)) • Homework: testing more 'helpful' thoughts on one occasion	• Introductions • Gained consent for writing up case study as PPR • Explaining principles of BCBT • Gather additional information regarding situations that lead to child experiencing anxiety • Explain how parent can support the intervention • Explaining importance of gradual 'exposure' to anxiety-provoking situations

Session 2

Child (45 mins)
• Review of last week's session • Review of homework • Exploration of core beliefs • Introducing idea of 'negative automatic thoughts' (NATs) with examples – how do these affect our feelings and behaviour? Stopping these thoughts. • Importance of exposure – how avoidance maintains anxiety • Homework: practice stopping the NATs during exposure to an anxiety-provoking situation

Session 3

Child (45 mins)
• Review of last week's session • Review of homework • Introducing idea if 'thinking errors' • What thinking errors do you make? • Homework: Thoughts and Feelings Diary, particularly for situations when child is exposed to anxiety-provoking situations (e.g. bed time, before school)

Session 4

Child (45 mins)	Parent (15 min phone call)
• Review of last week's session • Review of homework • Turning unhelpful thoughts into more helpful ones • Identifying physiological symptoms of anxiety • Relaxation techniques	• Brief phone call to discuss progress and how intervention is going

Session 5

Child (45 mins)
• Review of last week's session • Finding evidence to challenge the unhelpful thoughts • Introduce idea of positive self-talk • Homework: practice positive self-talk during exposure to anxiety-provoking situation (arriving at school and separating from mum)

Session 6

Child (45 mins)
• Review of last week's session • Review of homework • Development of 'gradual exposure' plan for bed time – an area which John was particularly reluctant to discuss and try

NB. Unfortunately, John was absent for this session due to illness. Session 6 and 7 had to be combined into one slightly longer session (1 hour).

Session 7

Child (45 mins)	Parent (30 mins)
• Review of intervention – what have you learned? • What aspects have been most helpful?	• Review of intervention • Sharing gradual exposure plan for bed time

As John was still experiencing difficulties (especially with regards to going to bed alone), further sessions will be planned for the next term (September 2013).

PPR 3: Assessing family strengths:
An approach based on family resilience

Abstract

Within Educational Psychology (EP) practice, it is common to focus on problems, difficulties and deficits, rather than focusing on strengths. Strengths-based practice, which finds its origins in community psychology and within positive psychology approaches, has shown positive outcomes in a range of settings including social work and clinical psychology (e.g. Early, 2001; Rashid and Ostermann, 2009). Within one Local Authority (LA), a strengths-based approach to working with families was developed. An interview schedule and set of rating scales were developed based upon a family resilience framework: the Key Processes in Family Resilience Model developed by Walsh (2006). These were trialled on a small sample of four parents. The interview schedule helped identify strengths within each of the families and all of the parents were able to identify ways in which they could build on these strengths. The parents' responses to this strengths-based approach were positive. Implications for working with families and EP practice are considered.

Introduction

It is common for professionals, such as Educational Psychologists (EPs), to focus on a child's problems and think of ways to intervene; a key example of this is the influential Monsen et al. problem-solving framework (Monsen & Frederickson, 2008). This model is taught to Trainee EPs as part of the doctoral training course at the

University of Birmingham and could be interpreted as implying that a key role of the EP is to 'fix problems'. Such an approach could be perceived as negative, as by focusing on problems, we may be neglecting the wide range of strengths and competencies that a child might have. Other elements of EP practice also seem to focus on difficulties, such as the process of obtaining a placement for a child at a special school which requires documentation of their deficits and the things that they cannot do (Morrison, et al., 2006), whilst neglecting all of the things they can do. Therefore, taking a strengths-based approach may be a more favourable alternative. Blundo (2001) suggests that this approach 'challenges our personal and professional conventions' (p. 296) and requires 'a shift in how we think and view the world' (p 297).

This PPR focuses on working within the context of the family, with a particular emphasis on strengths within families. I selected this particular area as I was interested in strengths-based approaches to assessment within EP practice, but also felt that I had had only limited experience in working directly with families and parents, other than through consultation focusing on their child. I have worked closely with children and parents individually, but have not engaged in any work that has addressed the needs of the family as a whole. A key message within this PPR is that all families have strengths and abilities, and families grow and develop from these strengths and abilities (Walsh, 2006). The problem is the problem – the family is not the problem.

This PPR outlines a strength-based approach to working with families and identifying their strengths using an interview schedule based on the Key Processes in Family Resilience Model developed by Walsh (2006). I aim to illustrate that such a strengths-based approach can be adopted in EP practice, rather than focusing solely on problems of deficits. I will begin by outlining the national and local context in which this research developed. My literature review will outline key issues relating to strengths-based assessments, resiliency and working with families, and introduce the concept of family resiliency. I will then describe the development of the interview schedule and the findings from piloting this. The discussion will focus on the effectiveness of this approach and implications for EP practice.

National context

Since the Department for Education and Skills review of the functions of the Educational Psychologist (EP), and within the LA in which I work, there appears to have been an increasing focus on EPs working at a community level, rather than focusing solely on the individual child (Farrell et al., 2006),. This means that EPs are likely to work closely with families in a variety of different capacities, such as providing advice regarding a child's special educational needs (SEN), training for parents, support at times of transition, and so on (Farrell et al., 2006). With the new Draft SEN Code of Practice (Department for Education, 2013), it is also likely that EPs will continue to work closely with families as well as children. The Draft recommends a 'family-centred approach' to supporting children with SEN, where parents, young people and children are all actively involved in every aspect of their

SEN, the idea being that everybody is involved in 'working together for positive outcomes' (p.26, DfE, 2013). As such, it is my belief that EPs will continue to work closely with parents and families, rather than focusing solely on the child.

Over recent years, the UK Government appears to have placed increasing importance on the role of the family in promoting a child's well-being, academic achievement and development (James, 2009). The previous Labour government focused on reshaping children's services by encouraging multi-agency working through the 'Every Child Matters' agenda, and the SureStart programme which aimed to support the most vulnerable families (James, 2009). They aimed to provide better support for parents through SureStart Children's Centres, intensive support and a key worker approach for the families that needed it most and improving partnerships between schools and parents (Department for Children, Schools & Families, 2007). Although these Children's Centres were originally positioned as highly effective at supporting families and achieving positive outcomes, questions have recently been based regarding their effectiveness due to a lack of clarity regarding their purpose and the different approaches that each Centre has taken; the government have proposed a national framework for addressing these concerns, as well as outlining who these Centres are for (House of Commons Education Committee, 2013).

A more recent policy of the current coalition government that is relevant to this research is The Troubled Families Programme (Department for Communities and Local Government (DCLG), 2012). This policy aims to provide additional support for

families experiencing multiple social issues (such as domestic violence, relationship breakdown and mental health problems) that have been linked with poor long-term outcomes; this support will be provided through Local Authorities (LAs) (DCLG, 2012). This payment-by-results scheme has led to many LAs, including the one in which I am currently employed, focusing on working with families that meet the criteria to be designated as a 'Troubled Family', with the hope that this will help 'turn these families around' (DCLG, 2012). The national criteria includes those families involved in crime or antisocial behaviour, families where children have poor attendance at school, are at risk of exclusion or attend a Pupil Referral Unit, and families where the adults are in receipt of out of work benefits. In a press release from the LA in which I am currently employed, in May 2014 more than one hundred of these 'troubled families' within the city had been 'successfully turned around'. The press release claims that the programme has helped children re-engage with school, reduced levels of crime and antisocial behaviour and helped parents find work. Seventy agencies have been involved with this programme and to date there is no indication of which, if any, of these agencies has had the most significant impact on the lives of these so-called 'Families in Focus'.

Local Context

This research was undertaken in a LA covering a densely populated city within the West Midlands. The current population within this city is estimated to be around 250,000. The latest Indices of Deprivation suggest that this city is the 20th most deprived LA in the country and deprivation in the city continues to rise. Around 33%

of children within the city are characterised as living in poverty. Approximately 7.5% of working age people are claiming Job Seekers' Allowance. The Multi-Agency Support Team (MAST) in which I am a Trainee EP covers one of the most deprived areas of the city, with higher than average unemployment, poorer health outcomes and higher crime rates than other parts of the city. This highlights the range of difficulties that families within this city may face.

Within the LA where I am currently employed, there has been an increasing emphasis on work with families, and particularly with parents, during the time that I have worked there. Since 2012, this has been in line with The Troubled Families programme (DCLG, 2012), which has been re-titled the 'Families in Focus' programme within my LA, perhaps to reduce the stigma associated with being designated a 'troubled' family. This has resulted in the recruitment of additional Parent Support Advisors (PSAs) within each MAST and all professionals (including EPs) within the MAST have been briefed on the programme and the ways in which we should be supporting these 'Families in Focus'. These families are identified by meeting at least two of the national criteria (detailed in the previous section) and at least one of the local criteria: families where at least one child is on the edge of being taken into care, families where there is domestic violence, mental health issues or substance misuse, families that live in one of the six priority areas identified by the police (which includes the area in which my team is based), and families where at least one child is at risk of gang involvement or sexual exploitation.

Literature review

My literature review was carried out using the University's online library 'Search' feature, looking for key terms such as 'strengths-based assessment' and 'family resilience'. Research from 2000 onwards was included, to ensure that the literature review reflected only the most current trends in research in this area. Four earlier papers (Patterson, 1988; Patterson & Garwick, 1994; Saleebey, 1996; Walsh, 1996) were also included, as it was felt that these were seminal papers in the areas of strengths-based approaches and family resilience. Earlier research into resilience was also included, to provide the historical theoretical background behind the Walsh (2006) model.

Strengths-based approaches

Strengths-based approaches seem to originate from the work of community psychologists in the 1970s (Orford, 1992), and also have a basis in positive psychology. Resiliency theory has also been influential in this area of work (Walsh, 2006). Seligman and Csikszentmihalyi (2000) criticise the 'exclusive focus on pathology' (p.5) in psychology and suggest that by instead taking a positive psychological approach it is possible to build on strengths and positive qualities to generate positive outcomes. Chafouleas and Bray (2004) suggest that positive psychology encompasses a range of ideas that are popular in the media, such as well-being, happiness, quality of life and positive emotion. They also promote the idea of moving away from studying pathology and deficits, and instead suggest that

rewarding talents and focusing on strengths can promote mastery and success in any area (Chafouleas & Bray, 2004).

Table 1 (adapted from Saleebey, 1996) highlights some of the key differences between a deficit-focused approach and a strengths-based approach, although these approaches can be combined to form an approach where strengths and deficits are considered together (Blundo, 2001). In my opinion, this clearly demonstrates the positivity and optimism that are embedded in a strengths-based approach and the potential benefits of taking such an approach.

Deficit-focused	**Strengths-based**
Person is defined as a 'case'; symptoms add up to a diagnosis.	Person is defined as 'unique'; talents, resources add up to strengths.
Therapy is problem-focused.	Therapy is possibility focused.
Practitioner is the expert on clients' lives.	Individuals, family and or community are the experts.
Resources for work are the knowledge and skills of the professional.	Resources for work are the strengths, capacities, and adaptive skills of the individual, family, or community.

Table 1: Differences between deficit- versus strengths-based approaches (adapted from Saleebey, 1996)

Strengths-based approaches have been used in a variety of settings. For example, Early (2001) suggests that a strengths perspective is 'increasingly a preferred mode of practice' (p.225) within social work. Having worked closely with social workers during my time as a Trainee EP, I am unsure whether this idea is reflected in

practice; although social workers may state that they are taking a strengths-based approach, my experience has indicated that social workers still tend to focus on deficits and challenges faced by a family during their assessments.

Nevertheless, McCammon (2012), an influential psychologist and author in this area, promotes the use of strength-based planning and the importance of incorporating strengths in interventions in care planning for young people with emotional and behavioural problems. McCammon (2012) forcefully advocates for a strengths-based approach in her persuasive article, highlighting the potential benefits of adopting such an approach and discussing the range of other published literature that has supported this argument.

Woodland et al. (2011) describe a range of strengths-based assessment tools, and argue in favour of the utility of these in assessing strengths in residential treatment facilities. They suggest that such an approach may be beneficial as it would provide a more holistic view of the child, rather than a one-sided view focusing only upon their difficulties (Woodland et al., 2011). They suggest that an holistic view can be useful in intervention planning and improving residential care facilities (Woodland et al., 2011). Despite forcefully presenting this argument, it is important to note that Woodland et al. (2011) did not carry out any empirical work to support their claims; I feel that it would strengthen their argument further if they were able to provide evidence that suggested adopting such an approach provided more robust

assessments and more positive outcomes in the residential treatment facilities that they describe.

Such approaches have also been used in clinical psychology practice. For example, Rashid and Ostermann (2009) suggest that deficit models of assessment 'paint an incomplete picture of the client' (p.490) and suggest that disorders such as depression and anxiety should be viewed as a lack of strengths, rather than deficits. They present a case study example where by re-framing an individual's depression as a lack of strengths, the individual was able to build on her strengths to overcome her difficulties.

Strengths-based approaches to working with children and young people in schools are beginning to emerge (Bozic, 2013). Strength-based assessment with children has been defined as 'the measurement of those emotional and behavioural skills, competencies and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social and academic development' (p.207, Rudolph & Epstein, 2000). It could be argued that this particular definition offers a rather within-child notion of strengths, but it does emphasise the positive features on which a strengths-based approach would focus.

Terjesen et al. (2004), in a paper exploring how school psychologists can use positive psychology in their practice, also note that 'fostering positive qualities [strengths] will be more effective than remediation of problem behaviour' (p.171). Terjeson et al. (2004) identify key ways in which school psychologists (whose role in the USA is broadly similar to that of the EP in the UK) use positive psychology and strengths-based approaches in their practice: through promoting concepts such as flow (where a person is completely absorbed in what they are doing, resulting in positive outcomes) and positive affectivity (where a person is successful as a result of experiencing positive emotions), which suggest that positive emotions lead to optimal functioning; through positive psychology and consultation work, where strengths can be reinforced and used to prevent future problems occurring; and through direct work, by teaching optimism and helping individuals focus on their own strengths. It is important to note that Terjeson et al. (2004) describe ways in which positive psychology and strengths-based approaches have been used by school psychologists, but do not provide empirical evidence or data to support their claims that such an approach has beneficial outcomes. Further research is required in this area to explore the effectiveness of the different techniques described.

Brownlee et al. (2012) also focus on the way in which strengths-based approaches can be utilised in schools, with a particular focus on the classroom. They suggest that positive expectations and positive relationships allow a student to promote their strengths; these strengths can then be explored and shared with others, who can reflect on how the student can use these strengths to achieve and overcome difficulties (Brownlee et al., 2012). It should be noted that strengths-based perspectives within psychology, including EP practice, have only recently begun to

emerge and, as such, do not yet have the rigour of more established methods (Saleebey, 2001).

Research has also explored how focusing solely on a child or young person's difficulties results in poor perceptions and negative expectations from school staff, including teachers and childcare professionals. For example, Donovan and Nickerson (2007) explored the impact of strengths-based data on multi-disciplinary team members' perception of students with emotional and behavioural difficulties. They found that this data led to more positive predictions of outcomes for these young people. Wellborn et al. (2012) also found that information relating to a child's strengths was associated with more positive teacher expectations. Campbell et al. (2001) uncovered similar findings with relation to staff's views within a childcare setting, and found that a solely deficit-based perspective led staff to believe that they could not care for the child with special educational needs within their setting.

Clonan et al. (2004), in a review of recent applications of positive psychology within schools, promoted the idea of fostering strengths to aid competence development and to boost resiliency. Much of the research into strengths-based approaches has touched on factors that could be linked to the wide range of research that has focused on individual resilience, which will be outlined in the next section. Clonan et al. (2004) discuss historical and emerging trends relevant to this area, and offer a description of current approaches used within schools that adopt such an approach. They discuss the reported benefits of these approaches, but offer no empirical

research of their own. It seems that within the literature focusing on strengths-based approaches, many different methods of using such an approach have been identified; however, further empirical evidence is required to support and highlight the potential benefits of applying these approaches.

It is important to note here that adopting a strengths-based approach may be a more positive method than traditional deficits-based approaches, and may result in positive outcomes. However, adopting such an approach may be impractical where other individuals, such as school staff or social workers, reject strengths-based approaches as simply reframing deficits (Saleebey, 1996) or ignoring potentially important difficulties or problems that a family might be facing. If a strengths-based approach is to be used effectively, it may be vital to ensure that all individuals involved are willing to adopt such an approach.

Resilience

Resilience has been defined as 'the capacity to rebound from adversity strengthened and more resourceful' (p.4, Walsh, 2006). Interest in this area began to grow after World War II, as researchers began to question why some people were able to maintain a high level of functioning after experiencing harrowing conditions and extreme adversity, such as in the Nazi concentration camps (Seligman & Csikszentmihalyi, 2000). Research has found that individuals are not born resilient, but instead become resilient through their experiences: 'resilience is forged *through* adversity, not despite it' (p.7, Walsh, 2006). Resilience can be seen as the

interaction between nature and nurture, encouraged by supportive relationships with others (Rutter, 1999).

Over the past three decades, a wide range of studies (e.g. Kaufman & Zigler, 1987; Garmezy, 1991) have been published that examine individual resilience and it has emerged as an important concept in child development and mental health research (Walsh, 1996). These studies have countered the view that difficulties and adversity experienced in early life lead to difficulties and deficits in adulthood; instead, negative experiences may lead to individuals becoming stronger and more able to cope positively with future life events (Garmezy, 1974; Rutter, 1985).

Research into resilience has tended to focus on the individual and their traits or dispositions (Walsh, 1996). However, researchers have also noted the key protective factors that lead to resilient individuals, including the importance of relationships. Positive relationships within a family and the wider community have been found to aid resilience (Walsh, 1996).

Family resilience

The research on individual resilience has increasingly led to a relational, or systemic, view of resilience (Walsh, 2006). Increasingly, research has shown that the most resilient individuals have family and social networks that act as protective factors, reducing their vulnerability and increasing their ability to cope with adversity (Walsh,

2006). Instead of viewing resiliency as an individual trait, perhaps 'within' the individual, it is perhaps more useful to consider resiliency as a relational trait that is based within and between different networks of social support, such as the family. This idea seems to have common sense appeal, as it seems unlikely that an individual could cope with the most extreme adversity without the support of other people around them. Of particular interest to the present research is the idea of 'family resilience' which 'offers a useful framework to identify and fortify key processes that enable families to surmount crises and persistent stresses' (p.261, Walsh, 1996).

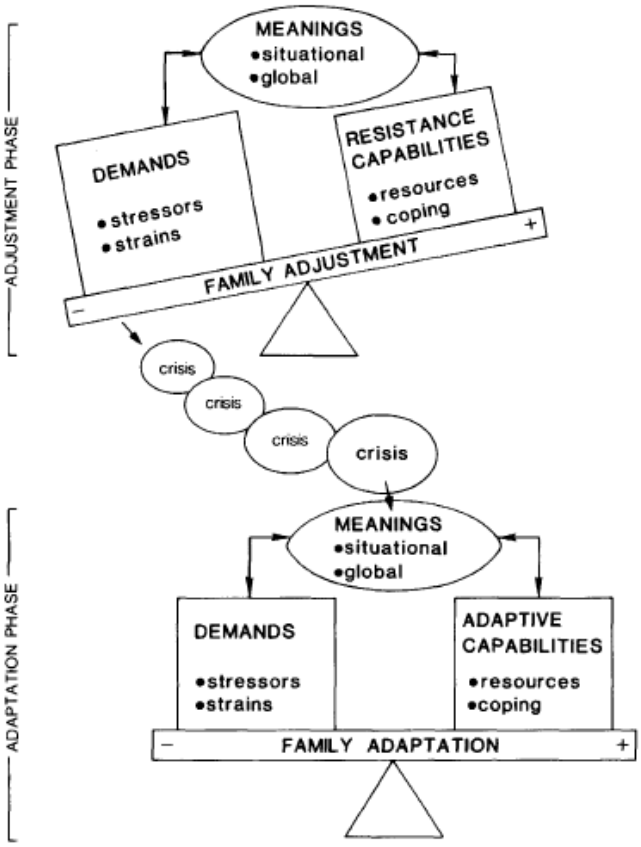

Figure 1. The Family Adjustment and Adaptation Response (FAAR) Model (Patterson, 1988).

Perhaps the earliest researcher to focus on this idea of family resilience was Patterson (1988) and the Family Adjustment and Adaptation Response (FAAR) Model, highlighted in Figure 1 above. This model focuses on three levels of systems: the individual, the family and the community. The main emphasis is on 'the family system and its efforts to maintain a balanced functioning by using its capabilities to meet its demands' (p.202, Patterson, 1988). This model shows that when demands upon the family build up, they have to adapt, building new capabilities to restore equilibrium. The meanings that a family attribute to the crises and the appraisals they make are also significant in aiding the family to adjust and adapt (Patterson, 1988) and are based on situational meanings, their identity as a family and their world view (Patterson, 2002). This model has been supported by empirical findings, particularly relating to families coping with childhood illness (e.g. Tak & McCubbin, 2002; Patterson et al., 2003). The empirical findings related to families coping with childhood illness provide support for this model. However, the utility of this model outside the medical field is less clear; little research has been conducted that applies this particular model to more 'everyday' family difficulties, such as financial hardship, unemployment and relationship issues. It may be that an alternative model, such as Walsh (2006), provides a better framework for exploring these types of family issues.

Patterson (2002) later went on to identify the key family processes that enable a family to adapt and adjust to crises, including cohesiveness, flexibility, affective and instrumental communication and behavioural control. Family resilience was viewed as 'an ongoing, often emergent process in families and not a stable trait' (p.237, Patterson, 2002). It was suggested that through experiencing stressors and crises,

families are required to learn new capabilities in order to be able to adapt and adjust. This is similar to views on individual resilience, but suggests that the family unit as a whole may be resilient, rather than individuals within that unit.

Walsh (1996) has also explored the concept of family resilience, and has suggested that stress and crises are experienced by all families throughout their life course, but noted that some families were more able to rebound from these. Walsh (1996) aimed to explore the key processes that help a family to cope with crises and emerge as a resilient family so that 'clinicians can mobilise untapped resources, enabling distressed families to cope more effectively and rebound strengthened through their mutual support and collaboration' (p.272).

Walsh (2002) began to develop a family resilience framework which identified the key family processes that reduce the risk of stress and dysfunction, and encourage growth and healing after a crisis. It was hoped that this model, or conceptual map, could then be used in a variety of resilience-based interventions, as these key family processes could be targeted (Walsh, 2002). She also provides illustrations of how this model can be applied to a variety of different crises, such as job loss, serious illness, death and work-related trauma (Walsh, 2002).

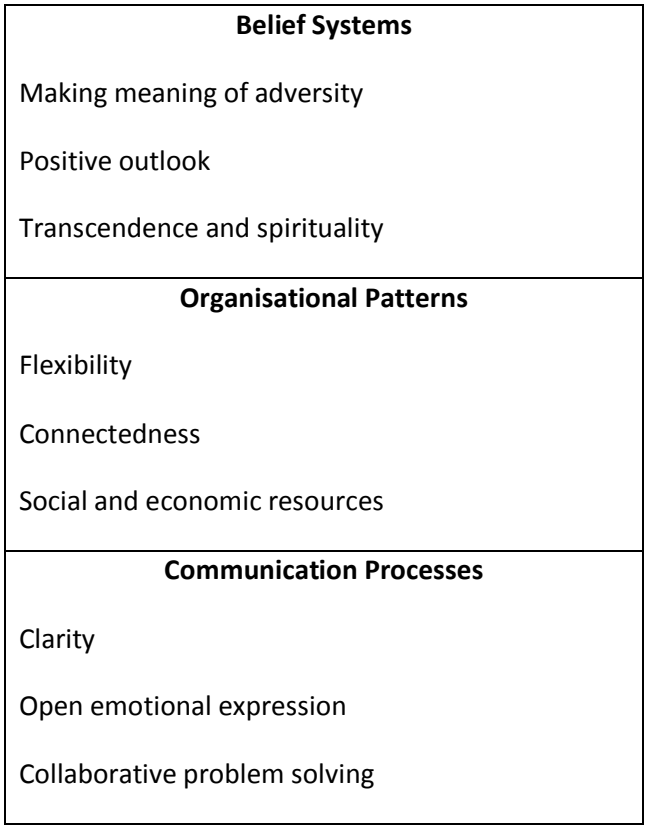

Figure 2. The Key Processes in Family Resilience Model by Walsh (2006).

Figure 2 illustrates the Key Processes in Family Resilience Model developed by Walsh (2006). This conceptual framework consists of three domains: Belief Systems, Organisational Patterns and Communication Processes. Within each of these three domains, Walsh (2006) identifies the key processes that are at the core of family functioning and family resilience.

A strengths-based approach to working with families

Although utilised in a variety of settings and across a range of professional contexts, and despite having a range of positive and empowering outcomes, strengths-based approaches are just an approach rather than a well-developed theory (Rawana &

Brownlee, 2009). Therefore, if these approaches are to be more widely used in EP practice, it would be helpful to have a range of established tools and resources.

By providing such a framework as that presented in Figure 2, Walsh (2006) suggests that a family's strengths and vulnerabilities can be identified and these in turn can be used to aid intervention planning in order to strengthen the family and boost their resiliency. By focusing on strengths within a family, opportunities are created for 'competencies to be learned or displayed, environmental modification and advocacy' (p.225, Early, 2001).

Dunst et al. (1994) and Laursen (2000) suggested that all families have resources, strengths and assets and that families should have the right to make decisions about their current situation and their future. Therefore, a strengths-based approach, which views the professional as a supportive partner, rather than an expert, could form an appropriate and positive way to working with families. The professional's role will be to help the family identify their own strengths and use these to bring about change for that family. It is important to note that this approach is still developing, and as such methods for working with families from a strengths-based perspective are fairly new and do not yet have the rigour or empirical support of more mature methods (Saleebey, 2001). However, this is not to say that such approaches are not worthwhile; further evidence evaluating the outcomes of adopting a strengths-based perspective in a range of professional fields will help to support the application of this approach.

Within social work practice, a range of measures for assessing strengths within families have been developed such as the Family Resource Scale, the Family Functioning Style Scale and the Family Empowerment Scale (Early, 2001). However, for EPs there appears to be little focus on this area within current practice.

Using the Key Processes in Family Resilience Model (Walsh, 2006) as a framework, I hoped to develop an interview schedule and a set of rating scales that could be used with parents to draw out the strengths within a family. These strengths could then be used to aid intervention planning, which could be supported by professionals within the MAST in which I work, such as the EP or PSA. These professionals regularly have contact with parents and families, and are well-placed to help families to identify their strengths and support them in building on these. To my knowledge, this particular model and approach have not been utilised in this way before.

Such an approach would be in contrast to some of the other measures and ways of working adopted by these professionals. For example, the PSAs regularly deliver parenting programmes, such as Triple P (Sanders, 2008), which help parents to address the challenging behaviour of their children. A strengths-based approach would perhaps instead focus on a child's positive qualities, and how these can be used to increase incidents of positive behaviour. Similarly, EPs often rely on cognitive assessments or attainment tests that aim to identify where a child has a particular difficulty. When working with parents, EPs often focus on the 'problem' that the child might have and look at ways to address this (Monsen & Frederickson,

2008). A strengths-based approach would instead consider the child's strengths and how these can be promoted.

Research questions

The literature review led to the development of the following research questions:

- To what extent can the Key Processes in Family Resilience Model (Walsh, 2006) be used as a framework to identify strengths within families?
- To what extent can these identified strengths be used to develop an action plan?
- How did the parents view the use of a strengths-based approach?

Methodology

This PPR aims to explore whether the Key Processes in Family Resilience Model (Walsh, 2006) could be used as a framework for identifying strengths within families. In order to answer the research questions, it was necessary to develop a research tool. In this section, I will outline initially my epistemological stance, followed by detailing how I used the Walsh (2006) model to develop an interview schedule and a set of rating scales in order to identify and explore a family's strengths. I will then provide information regarding the process of trialling these research tools.

Epistemology

My epistemological stance is one of critical realism (Bhaskar, 1998). Critical realism can be thought of as an integration of positivist and relativist approaches, describing the interaction between the natural and the social worlds, and suggests that any findings can be explained by more than one different theory (Robson, 2002). Critical realism suggests that we can explore the social world be examining the structures or mechanisms which generate the world (Bryman, 2008).

The research tools developed and the collection of data aimed to encourage parents to use the Walsh (2006) model to explore their own context with the support of the Trainee EP, and the PSA who has been working with the family. The aim is to explore the 'mechanisms' (perceived strengths) that influence the family and their functioning.

A critical realist perspective is interested in subjective interpretations of reality and hypothesising about the unobservable mechanisms that generate the world (Robson, 2002). In this study, the subjective interpretations of the parents will be explored, with the hope that the mechanisms that generate their experiences (i.e. their family's strengths) will be revealed. The Trainee EP and PSA may influence these interpretations and lead to a co-construction of reality. Nevertheless, it would be hoped that the approach adopted would reveal the structures or mechanisms that lead to the family's life experiences, as the influence of other people is likely to be another mechanism that affects the way in which we experience reality.

Developing the research tools

In order to gain an individual's own views of the strengths that lie within their family, I decided that a qualitative approach, such as an interview schedule would be the ideal tool. A semi-structured interview schedule was considered to be desirable, as this would allow for greater flexibility and the opportunity to ask further questions, which other methods such as questionnaires or structured interviews would not (Bryman, 2008). Social desirability bias, where the interviewee provides the answers that they think the interviewer wants to hear, is a limitation of interviews as a method of data collection. However, I felt that this was not a significant issue in the present context, as I hoped to provide an open forum where the parent would feel comfortable to speak freely. Similarly, the interview method allowed for the co-construction of responses between the interviewer and interviewee (Bryman, 2008); this was thought to be beneficial in helping the parent identify their family's strengths as this is something that they may not have considered before, particularly when working with professionals who may have utilised a more deficit-based approach in past interactions.

The questions were based on the domains identified in the Key Processes in Family Resilience Model (Walsh, 2006). Within each domain, three main questions were selected that reflected the three processes of family functioning. Each main question also had a follow up question, which would be used to prompt the interviewee to provide more information relevant to that process. Table 2 below illustrates the

processes within each domain and the question and follow-up question (in brackets) selected, that aim to explore that process within the interview schedule.

The interview schedule was based on the criteria suggested by Robson (2002) including an opening introduction, the main questions of the interview, and ‘closure’ where the interviewee was thanked for their participation.

Domain	Process	Questions
Belief systems	Making meaning of adversity	When faced with this problem/difficult situation, were you able to make sense of it? (Were you able to make sense of the situation and explain it to your children?
	Positive outlook	How did you stay positive/remain hopeful for the future when faced with the difficult situation? (Were you able to accept the things that could not be changed?)
	Transcendence and spirituality	Were you able to see 'the bigger picture'? (Who or what did you look to for inspiration? (e.g. religious group, community))
Organisational patterns	Flexibility	How did you continue with daily routines and provide stability for your children? (Were you able to be flexible/adapt to changing circumstances?)
	Connectedness	Within your family, how do you support each other when facing challenges? (How are you able to rely on each other?)
	Social and economic resources	Who do you turn to when you need help or want to talk? (Who do you turn to outside of the family?)
Communication processes	Clarity	What ways did you use to communicate with your family? (How did you communicate openly and clearly about difficulties with your family?)
	Open emotional expression	In your family, to what extent do you feel able to share and express your feelings? (What about your ability to support the feelings of your family?)
	Collaborative problem solving	What ways do you use to solve problems within your family? (e.g. goals, 'Plan B') (How do you work together/make decisions together?)

Table 2. Interview questions and their links to the key domains and processes of family functioning identified by Walsh (2006).

Open-ended questions were selected to allow the interviewees to answer however they wished and to allow for any unusual or unexpected answers relating to family functioning that the interviewer might not anticipate (Bryman, 2008). In particular, I did not want the questions to lead the interviewee to give a particular response (e.g. a 'yes' or 'no' answer), but instead wished to explore the interviewee's own insight and perceptions.

The processes identified within each domain are based on extensive research into family functioning (Walsh, 2006). The questions were carefully written to map onto each process as neatly as possible. Therefore, it would be hoped that the validity of each question (i.e. that they provide a measurement of that particular process) is fairly high, due to the empirical support that Walsh (2006) presents relating to each process of family functioning.

The questions were purposefully worded to have a positive slant and to be leading the interviewee to answer in a particular way. This may lead to concerns that the responses will be biased (Bryman, 2008). However, as the aim of the research is to elicit strengths, this positive bias is not an area of concern.

In order to assist interviewees in responding to the questions, some of which are quite abstract, I decided that it would be helpful to first prime their memory of a difficult situation or problem that they have faced with their family. I felt that by

asking them to reflect on this initially, it would help bring to mind the processes that were involved and thus reflect on these in their answers.

I also wanted to use rating scales alongside the interview schedule, as I felt that these could potentially be useful to gather some quantitative information about how the different strengths compared, and also for recording a family's progress following the implementation of interventions to boost their strengths (i.e. as a pre- and post-intervention measure). After answering each question, the interviewee would be asked to rate themselves on a scale of 0-10 (with 10 being the strongest) for that particular process. Such an approach was adopted as this allows the interviewee to make a finer distinction between each process (Bryman, 2008) and identify where the relative strengths were within their family (i.e. a higher score on the scale indicates that that process is more of a strength).

Although rating scales of this type are often used in psychological research (Bryman, 2008), their validity and reliability has been questioned. For example, as the interviewee only rates themselves once on each process, there is no way of determining internal validity. It is also difficult to determine whether the rating scale actually measures what it purports to measure. However, rating scales do provide a quick and easy method of obtaining a measure of an individual's perceptions.

Ethical considerations

The study was conducted in line with the British Psychological Society's Code of Human Research Ethics (BPS, 2010). Several ethical issues were considered during the design of this research:

- Consent: Parents were asked to volunteer to take part in this study and gave verbal consent to do so. They were told that they could withdraw their consent by indicating that they did not want to continue with the interview, if they wished.
- Debriefing: Once the interview had been conducted, the parents were given the opportunity to ask any questions which they had. I also attempted to summarise the items that we had discussed, along with the strengths we had identified through the interview, and the actions that we had identified together.
- Confidentiality: The parents had already been referred to the MAST and were aware of the team's procedures regarding sharing information (i.e. information would only be shared if necessary, and only with other professionals who needed that information) and had given consent for this.
- Data storage: The notes made during the interview were kept within the family's confidential paper file that is stored within a locked cabinet in the MAST's secure office.
- Risks: It was felt that there were limited risks to taking part in this study. The only potential risk identified was that by asking parents to reflect on a problem that they had experienced, they may have experienced distress. The Trainee EP and PSA were both skilled in working with parents in emotionally-charged

situations, and were on hand to provide additional support if this was deemed necessary.

Trialling the tools

The research tools were trialled with four different parents in an attempt to identify the strengths within their families. The parents were identified through convenience sampling, which involves 'choosing the nearest and most convenient persons to act as respondents' (p.265, Robson, 2002). I asked two of the Parenting Support Advisors within my team to identify two parents each. I asked them to select parents that they knew well (so that we would not have to spend time discussing the problems or difficulties that they were facing, as it was felt that this did not fit with a strengths-based approach) and were perhaps unsure of what to do next to work with these families.

The sample of parents consisted of one male and three females. All of the parents were of White British ethnicity and their ages ranged from approximately 25 to 40 years old. All four parents had between two and four children. Three of the parents were single parents. All of the parents lived within one area of the city in which I work.

I interviewed each parent in a private room in the team's office. Also present was the PSA that had been supporting that particular parent for some time. The reason for asking them to be present was to ensure that the parents felt comfortable talking to

an individual (myself) that they had not previously met. Similarly, I felt that it would be helpful for the PSA to be present so that they would be aware of the parent's views on the strengths within the family and so that they could be part of the action planning stage. During the interview, both the PSA and I made notes, recording some verbatim quotes as much as possible. After each question, I reflected back what the parent had said to ensure that I had captured their response accurately.

In order to explain the idea of a strengths-based approach to working, a short script was written that gave an explanation of the purpose of the interview and what it was hope would be achieved (see Appendix 1 for a copy of this script). The parents were then asked the questions on the interview schedule (see Appendix 2). Whilst they were answering the question, I made brief notes summarising their ideas, and checked back with them to check that I had understood and recorded accurately what they had said. The follow-up questions were asked as prompts if the parent did not address this question within their answer to the main question for each process. After each question, they were then asked to rate themselves on a scale of 0-10 for each of the processes (see Appendix 3). Any comments related to their rating were recorded.

Action planning

Once the parent had answered all of the questions, we looked back at their scores on the rating scale. Areas that were seen as strengths (i.e. those where the parent had rated themselves as 5 or above) were considered. I decided to use a solution-focused approach to explore these strengths. This approach was chosen as it is

commonly used in EP practice (Beaver, 2011) and is broadly strengths-based. A solution-focused approach assumes that all individuals are capable, that they have a good understanding of their situation and that they can be successful in changing their situation (O'Connell & Palmer, 2007).

Using a solution-focused approach (O'Connell & Palmer, 2007), I asked the parent to think about a way in which they could move one or two points higher on the scale (e.g. if they had rated themselves as a 6, how could they move to a 7 or 8?). The aim of this was to help the parent identify ways in which they could develop their existing strengths. Their ideas were recorded to form a short action plan. It was hoped that the parent would then be able to put these actions in place, with the support of the PSA if necessary, in order to build further on these areas of strength. At a later date, it was hoped that the PSA could return to these ratings, and ask the parent to rate themselves again, after they had had the opportunity to put the identified actions into place, thus providing a simple pre- and post-measure.

Evaluation of approach

After the interview, the parent was asked three short questions (see Appendix 4) to gain an idea of how they had found the procedure. In particular, I was interested in finding out how they had found the procedure of identifying strengths, if the interview had felt different from other meetings that they had attended with our team, and how they thought the meeting would help their family.

The parent and their family would continue to be supported by the PSA through a combination of one-to-one and group sessions. Thus, there would potentially be opportunity for further consideration of whether the strengths-based interview based on Walsh (2006) had led to positive outcomes for the family.

Findings

Identifying strengths

A brief form of thematic analysis was used to identify key themes within the data. Bryman (2008) defines thematic analysis as 'a term used in connection with the analysis of qualitative data to refer to the extraction of key themes in one's data' (p.700). Verbatim quotes that highlighted 'strengths' and 'actions' in relation to each of the processes were identified from the notes taken during the interview. This approach to data collection and analysis may not appear particularly rigorous, but it was selected as it seemed to be a 'natural' approach to work in this area, as the parents would be accustomed to being asked questions by the professionals in the MAST and with that professional making brief notes as they talked. A more rigorous form of data analysis would likely require the interviews to be recorded and transcribed; this was not felt to be desirable in the present study, as I wanted the interview to appear as 'natural' as possible to the parents, thus providing responses that could be expected in the MASTs day-to-day work.

All four parents were able to identify strengths within their family relating to the different processes identified in the Key Processes in Family Resilience Model (Walsh, 2006). Examples of these strengths are identified in Table 3 below.

Process	Example strengths
Making meaning of adversity	'We were able to talk about it… the other kids understood the situation and were supportive.'
Positive outlook	'Most of the time I can stay positive, but sometimes it's hard. I suffer with depression so I sometimes focus on the negatives, but I'm working with Healthy Minds and I'm getting better at being positive.'
Transcendence and spirituality	'We ordered a pizza and had a chat! I know my daughter… I knew everything would be ok.' 'Yes – I split up home, work and social life. If there are problems in one area, I focus on another. I also read a lot – this helps me 'escape' and realise things could be worse.'
Flexibility	'We just keep going and don't dwell on things.' 'We get done what needs to be done.'
Connectedness	'We provide moral support for each other… I don't want the kids to take on too much responsibility. We understand that we all care about each other.' 'We are there for each other. We listen to each other and know when to give each other space. We can rely on each other.'
Social and economic resources	'I'm really close to my mom and my sister. They offer a lot of support… They live nearby.' 'The girls at work help – they can sense when I'm not having a good day.'
Clarity	'It's better to talk in a group… We have a family meeting and get support from each other that way… I call everyone in.' 'We write letters to each other… and we have a 'feelings book' where we write notes. We write back to each other, and it's really positive.'
Open emotional expression	'Yeah – I do, honestly. We're all really open and say what we think! I can always tell if the kids are down… The kids ask for advice if they're worried about something.'
Collaborative problem solving	'We work together to solve our problems… we talk about everything…' 'It's about using what you've got… my oldest daughter helps me the most.'

Table 3. Examples of strengths identified by parents and the processes they relate to.

Rating scales

All of the parents were able to rate themselves from 0-10 on all of the different processes. There was a great deal of variation between their ratings. One of the parents also repeatedly commented on where she felt her family were now, and where they had been in the past before she had attended one of the parenting programmes run by the PSAs in our team. Parents rated themselves above 5 on most of the processes. One parent rated herself as only a 4 for 'Solving problems together' as she felt that her family tended to keep their problems to themselves and rarely worked together. One parent rated himself as only a 2 for 'Support from outside the family' as he recognised that he had a particularly challenging relationship with his mother, and did not feel he could talk to his friends about the family's problems.

Additional quantitative data related to the rating scales can be found in Appendix 5.

Action planning

All of the parents were able to identify actions that they could undertake to build on their family's existing strengths. Some examples are detailed in Table 4 below.

Process	**Examples of actions**
Making meaning of adversity	'It would be helpful if I separated the two children and talked to them separately.' 'I will make sure the kids are looking and listening to me when I'm talking

	to them.'
Positive outlook	'I'm going to try and look forwards.' 'I will keep going to my appointments with Healthy Minds, as they're helping me be more positive.'
Transcendence and spirituality	'I'm going to try and see the bigger picture… It won't be easy though… I need to stop worrying about what the outside world, like the neighbours and the police, think…'
Flexibility	'I think we need a proper routine. I often don't have time to do things coz I have lots of appointments. I don't have much free time.' 'I constantly feel tired, I feel like I'm going to faint or pass out. I'm going to change to a different doctor, coz my doctor's not very helpful. [The PSA] is helping me with this… If I didn't feel so tired I could put in a proper routine.'
Connectedness	'I'm going to try and spend quality time with each of the children.' 'I'm going to try and listen more and not be judgemental.'
Social and economic resources	'I'm going to try and talk to my dad more, get him involved in the kids' lives.'
Clarity	'I'm going to make sure we do talk about problems when we have them.'
Open emotional expression	'We'll keep doing the feelings book. But perhaps we'll try talking to each other about what we've written instead of just writing it down.'
Collaborative problem solving	'I'm going to try and include the children in what's going on a bit more… and let them be involved in decisions.' 'I'm going to try not to worry about worrying the kids with my problems.' 'We could spend more quality time together.'

Table 4. Examples of actions to build on the existing strengths and the processes they relate to.

Parents' views on the strengths-based approach

All of the parents were able to reflect on the interview procedure. All four noted that they felt listened to and found the interview provided an opportunity to talk. They also all made some comment on how positive the interview was and that it focused

on the good things about their family, rather than just the negatives or the family's problems. This was different from other meetings that they had had with members of our team. All of the parents said that they thought the interview was helpful as it either gave them things to think about, had provided them with the chance to explain themselves and how they feel, or given them actions which they felt would make things better and strengthen their family. It is important to remember here that through adopting a strengths-based approach, the parents may have made an assumption that I wanted them to be 'positive', thus leading to a potential positive bias in their responses to these evaluation questions.

Discussion

The findings highlighted above suggest that a strengths-based approach, such as the interview schedule based on the Key Processes in Family Resilience Model (Walsh, 2006), can be used to identify strengths within families, which can then be used to develop an action plan to further strengthen the family and build their resilience. The findings are in line with the critical realist epistemology adopted, as they provide evidence for the 'mechanisms' that generate the individual family's world and experiences.

Furthermore, the small sample of parents involved in this study found the focus on strengths to be a positive approach to working with professionals. This has implications for the ways in which professionals, including EPs, approach work with families and perhaps suggests that there should be a move away from deficit- or problem-focused approaches.

It is important to note that strengths-based perspectives within psychology, including EP practice, are still developing and do not yet have the rigour of more mature perspectives and methods (Saleebey, 2001). Tedeschi and Kilmer (2005) also note that methods for assessing strengths are widely used across a range of professional disciplines, but that there is little empirical support for these compared to deficit-oriented approaches. Despite these limitations, assessing strengths appears to provide a positive approach to working with families, that may lead to them feeling more empowered and motivated to build on their existing strengths. If we only focus on negatives, it may be that the individual or family group will feel negative about their situation, will only focus on the things that are problems and the things that they cannot do, leaving them feeling helpless and unable to see how things can change for them. It is also likely that focusing on a family's strengths and positive attributes will lead to a more positive relationship between the family and the professional (Tedeschi & Kilmer, 2005) and thus enable a more effective and collaborative approach to intervention compared to more 'expert models', where the professional is seen as the 'expert' and donates solutions and strategies to the family.

Patterson and Garwick (1994) argue that there has been little research to date that has focused on using the whole family system as the unit of analysis. Within the current study, this may be a potential weakness: the interview was conducted with only one individual within the family (one of the parents). Future research could explore using the interview schedule with all members of a family. It could be that the children, or other parent (where the family has two parents), would have different views on what they perceived the family's strengths to be. By involving everyone within the family, it might be possible to obtain a more accurate description of the

family's strengths and a collaborative approach involving all of the family could be used to identify potential actions to boost their strengths. It would also be interesting to involve members of the extended family and significant others, such as friends, who may be closely involved with the family.

Walsh (2002) argued that much of the research into family resilience has focused on white, middle-class, intact families who were not under stress. Although the sample used in this study did not fit into this niche, it did not include a particularly diverse range of individuals from different cultural backgrounds. As such, future research could focus on trialling the interview schedule with a wider range of individuals to determine its utility. It may also be helpful to trial the schedule with individuals with a range of needs including learning difficulties; some of the language within the schedule may be difficult for individuals with such difficulties to understand and therefore adaptations may need to be made to ensure anti-oppressive practice. It would be hoped that this approach, based on the Key Processes in Family Resilience Model (Walsh, 2006), will recognise diversity within families and will be applicable to a wide range, if not, all families. The model itself has been applied successfully with a range of families from different backgrounds facing different crises, such as job loss, reemployment, serious illness, death and loss, and war-related trauma and loss (Walsh, 2002).

Potential limitations of interviewing also need to be considered. For example, it could be that the parents responded to the questions in a way that was socially desirable. This social desirability bias may mean that their responses are an inaccurate

description of their family or their views (Bryman, 2008). However, I wished to explore the parent's views of their own situation and the presence of the PSA and the efforts to ensure that the parent felt at ease with the interview process would hopefully have reduced this bias.

Another limitation that came to light with regards to the interview schedule was that it may not be a good way of measuring family strengths within families with very young children. One of the parents interviewed had three children all under the age of five years old. She found it particularly difficult to answer questions related to explaining challenges to her children, supporting each other with challenges and solving problems with her family. This was due to the age of her children as she felt that she was unable to explain things fully to them because of their age. Similarly, their young age meant that it was unlikely that they would be involved in collaborative problem solving and supporting their parent with her problems. As such, this interview schedule may not be particularly helpful in identifying strengths within families with only young children, as some of the questions may be irrelevant. However, future research could look at developing different questions derived from the processes for this type of family.

The rating scale appeared to be a useful way of measuring perceived strengths within a family. Simply asking questions about perceived strengths would not have provided information regarding the relative position of the different strengths (i.e. one strength may be more significant, or 'stronger', than another). It is unclear how reliable or valid adopting such an approach is (Bryman, 2008), but as I was

interested in the subjective interpretations of the individual parents, this was not felt to be a significant limitation.

Criticisms of strengths-based approaches also need to be taken into account when considering the utility of the interview schedule based on the Key Processes in Family Resilience Model (Walsh, 2006). For example, Saleebey (1996) states that such approaches are often criticised for simply reframing 'deficits and misery' and 'ignoring or downplaying real problems' (p. 302). As such, it could be argued that utilising the interview schedule described in this study simply leads to the family's actual difficulties being ignored or missed. However, I would argue that all of the parents referred to at least one difficulty that they were currently experiencing within the interview. As such, their problems were not ignored or downplayed; instead, their problems were reframed in a more positive light and the parents were empowered by helping them to identify the strengths that their family had shown whilst tackling this problem. This argument is in line with Rudolph and Epstein (2000) who report that one of the key advantages of strengths-based approaches is that they can 'create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers and adults; and enhance one's ability to deal with adversity and stress' (p. 207).

In this study, focusing on strengths also provided the opportunity to involve the parent in planning future actions to build on their family's strengths. I felt that this was positive, as it helped to establish a range of positive expectations and showed the parent that I felt they could achieve positive outcomes, whilst also encouraging

them to take responsibility for developing their strengths (Rudolph & Epstein, 2000). Thus, the interview schedule is an empowering strengths-based approach which should be considered as conducive for bringing about change (Laursen, 2000). Further research could explore other ways in which the strengths-based information could be used to bring about change. For example, the top two or three strengths could be identified and combined to address a specific problem which the family were experiencing. Following this trial of the interview schedule, it would be hoped that the PSAs within the team would have the option to use this approach within their casework. For EPs engaging in family work, this interview schedule may also prove to be a useful technique for eliciting strengths.

It could be argued that the parent may have felt negative if they were unable to identify a strength or rate themselves highly on one particular process. However, I found that when this occurred, the parents were all able to reflect on other areas of strength and did not dwell on the areas where strengths were less obvious. I also framed these areas in a positive light: lack of a strength in one area is not a deficiency – it may be that the family has not had the opportunity to develop a strength in this area (Rudolph & Epstein, 2000).

A final note is that, due to timescales, the present study did not include a follow-up to determine whether the process of eliciting strengths and identifying future actions had had any impact on the family and their functioning. Future research could focus on exploring the specific effects on the parents' competencies and feelings when faced with a challenge following an interview where the family's strengths were

identified (Sheridan et al., 2004). Such a study should also select a larger sample than the present study, and include individuals from a more diverse range of backgrounds. A follow-up study could explore whether the parent had acted upon any of the action identified following the interview, and perhaps use the rating scales again to determine whether their family had built upon their strengths. All of the parents reported that they felt the process would be helpful, but this anecdotal evidence needs to be supported with further data before it could be concluded that the strengths-based approach had had a positive impact on the family.

Conclusions

Despite the limitations noted above, the interview schedule presented here, based on the Key Processes in Family Resilience Model (Walsh, 2006), appears to be a useful method of eliciting strengths within families. It is straightforward and simple to use and seemed to be a positive way of building rapport with a parent and helping them to see the positives within their present situation. In particular, adopting such an approach seemed to provide information that a deficit-based approach would not. This has implications for all professionals working with families, as by focusing solely on their difficulties, it may be difficult to identify ways forward for that family. The interview schedule here allowed strengths to be identified, and with solution-focused questioning (O'Connell & Palmer, 2007), actions to further promote these strengths were ascertained.

This has additional implications for EP practice with not just families, but also with children, schools and other professionals. Additional ways of adopting strengths-based approaches within our daily practice warrant further exploration; for example, it would be interesting to explore whether an approach to elicit strengths within individual children could be developed, or strengths-based models of consultation to be used with parents or school staff.

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Appendix 1

Identifying Family Strengths: Introduction

Often, when parents seek support or advice from our service (the MAST), the worker will ask them lots of questions about their family's 'problems' or 'difficulties'. This may make you feel quite negative about your own situation and this is not always helpful.

In meeting with us today, we hope to talk to you about some of the positive aspects of your family life and help you to identify the strengths that your family has.

If we can identify your family's strengths, we can build on these to address some of the areas where you might be experiencing difficulty. We hope that by working together we can increase your family's strengths, so that you are more able to deal with 'problems' or 'difficulties' in the future.

I will now ask you some questions relating to you and your family. After each question, I will ask you to have a look at these rating scales, and we will decide together where we think you and your family fit on this scale.

At the end of my questions, we will hopefully be able to identify your family's strengths. The PSA and I will then help you develop an 'action plan', looking at ways in which we can build on these strengths to help you and your family.

When we have finished, I will ask you a few further questions about how you found our meeting today.

Any questions?

Appendix 2

Identifying Strengths in Families: Interview Schedule

(based on Walsh (2006) Key Processes in Family Resilience)

Think of a problem/difficult situation that you have faced as a family, one that you have coped with…

Belief systems

- When faced with this problem/difficult situation, were you able to make sense of it?
  (Were you able to make sense of the situation and explain it to your children?)

- How did you stay positive/remain hopeful for the future when faced with the difficult situation?
  (Were you able to accept the things that could not be changed?)

- Were you able to see 'the bigger picture'?
  (Who or what did you look to for inspiration? (e.g. religious group, community))

Organisational patterns

- How did you continue with daily routines and provide stability for your children?
  (Were you able to be flexible/adapt to changing circumstances?)

- Within your family, how do you support each other when facing challenges?
  (How are you able to rely on each other?)

- Who do you turn to when you need help or want to talk?
  (Who do you turn to outside of the family?)

Communication processes

- What ways did you use to communicate with your family?
  (How did you communicate openly and clearly about difficulties with your family?)

- In your family, to what extent do you feel able to share and express your feelings?
  (What about your ability to support the feelings of your family?)

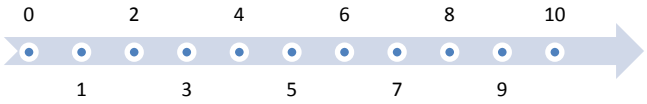
- What ways do you use to solve problems within your family? (e.g. goals, ‘Plan B’)
  (How do you work together/make decisions together?)

Appendix 3

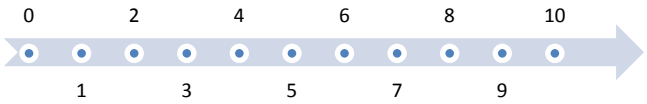
Identifying Family Strengths: Rating Scales

Comments

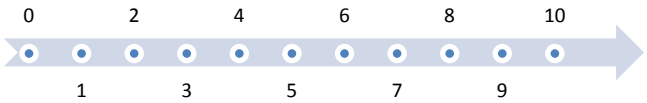
Making sense together



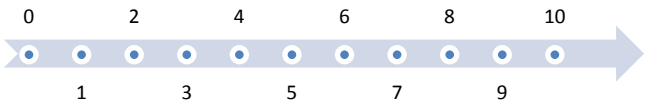
Staying positive



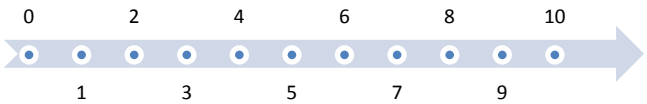
Seeing the 'bigger picture'



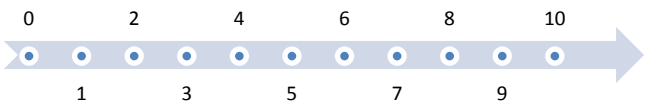
Structure and flexibility



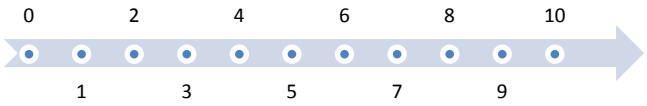
Supporting each other



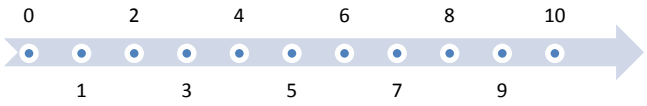
Support from outside the family



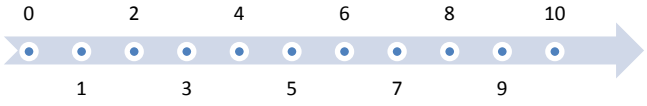
Family communication



Sharing and expressing feelings



Solving problems together



Appendix 4

Identifying Family Strengths: Post-interview questions

(Follow-up questions adapted from Chorpita, 2003)

1. How did you find today's meeting?
   (Did you feel listened to? Did you talk about what you wanted to talk about? Did you understand the things said in the meeting?)

2. How did it feel different from other meetings that you have had with professionals? (i.e. from the MAST)

3. How do you think that today's meeting will help you and your family?
   (Did you feel the meeting gave you ideas for what to do?)

Appendix 5

Quantitative data related to the rating scales

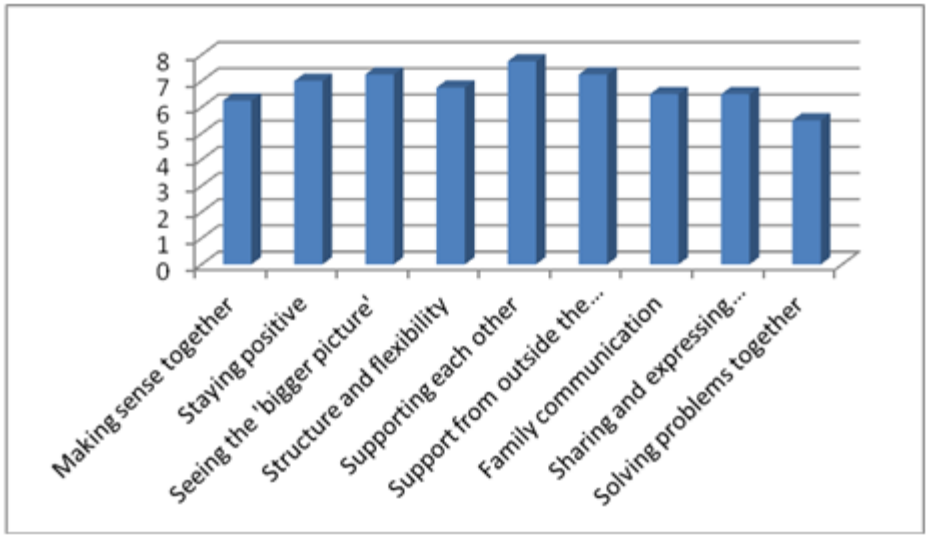


Figure 1. Graph to show average rating for each of the key processes.

Figure 1 shows that the average ratings ranged from 5.5 (for Solving problems together) to 7.75 (for Supporting each other). This shows that, on average, most parents viewed all of the processes as an area of strength (above a rating of 5). Staying positive, Seeing the 'bigger picture', Supporting each other and Support from outside the family achieved the highest average ratings. Solving problems together achieved the lowest average rating.

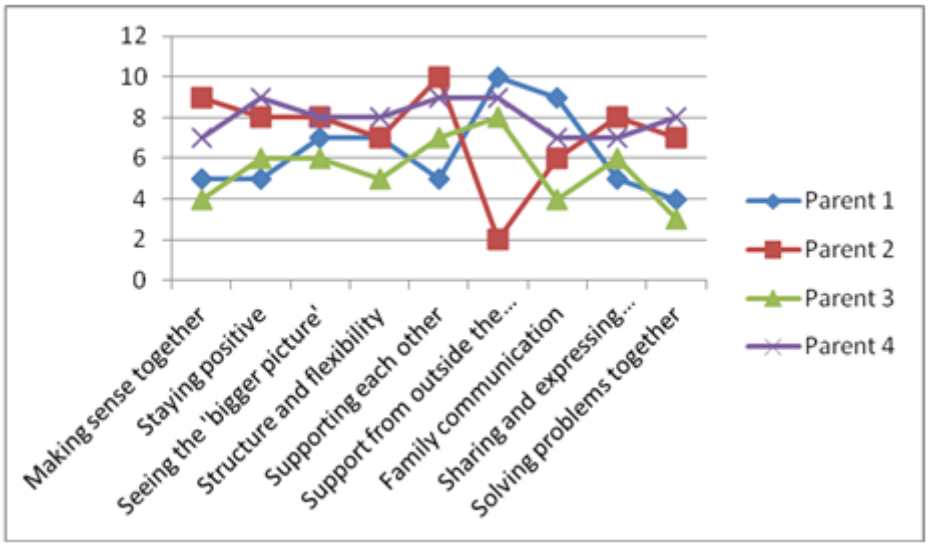


Figure 2. Graph to show ratings for each parent.

Figure 2 shows that there was a great deal of variation between the ratings that each parent gave to each process. These individual ratings show that it is possible to discriminate between strengths, and also that each parent identified different areas of strength within their own family. There does not seem to be a particular process that was consistently identified as an area of strength (or not) across the four parents sampled.

PPR 4: Increasing the capacity of Youth Offending Team (YOT) workers to identify speech, language and communication needs (SLCN) using an organisational development (OD) action research model

Abstract

International research has consistently found that a high proportion of young offenders have speech, language and communication needs (SLCN) compared to the general population. Estimates within the UK suggest that around 60% of young people involved in the youth justice system have these needs (Bercow, 2008), whereas within the general population this figure is only around 10% (Bryan et al., 2007). Interventions for these young people aim to rehabilitate them and reduce the risk of re-offending. However, these interventions tend to rely heavily on language and communication skills (Humber & Snow, 2001) and as such may have limited impact on young offenders with SLCN. The Youth Justice Board (YJB) has recently recommended that Youth Offending Teams (YOTs) assess young people for SCLN; this will become routine practice when AssetPlus (a computerised assessment tool used by YOTs) is implemented in 2014-2015. This report describes the process of implementing a screening tool for SLCN within one YOT in an urban city in the West Midlands, using an organisational development (OD) action research model. Findings from this process are presented, along with conclusions and potential implications for practice within YOTs and for EPs.

Introduction

Since the publication of the Bercow Report in 2008 (Bercow, 2008), children and young people with speech, language and communication needs (SLCN) have

received increasing attention. As speech, language and communication skills are used in almost everything that we do, it is vital that children and young people with difficulties in this area receive appropriate support and interventions.

According to a leading charity for SLCN, a child or young person is considered to have SLCN if: they have speech that is difficult to understand, they struggle to say words and/or sentences, they do not understand what is being said to them, or if they have difficulties knowing how to engage in a conversation (I CAN, 2014). A child or young person may have a combination of these difficulties. From this definition, it is clear that the term SLCN encompasses a broad range of needs which can be of differing severity and impact upon the individual's life and day-to-day functioning.

This Professional Practice Report (PPR) describes the process of implementing a screening tool for SLCN within a Youth Offending Team (YOT). This topic was selected as the focus for a PPR as SLCN is a particular area of interest for me, due to the number of children and young people that I have met who have this type of difficulty, but have often not been identified as such and as a result have not received any additional support. Also, my placement supervisor during the second and third year of the doctoral course is a Specialist Senior Educational Psychologist (EP) whose specialism is working within the YOT for one day per week. Through discussion, we noted that there were a number of young people involved with the YOT who appeared to have SLCN, but that there was no systematic way of identifying these young people and implementing appropriate support.

This PPR begins with a brief description of the national and local context in which the project took place. My literature review will highlight research that has explored young offenders with SLCN and the process of screening for this type of difficulty. I then describe the process of organisational change and present the organisational development (OD) action research model. Findings regarding this process are highlighted, followed by a discussion of these and implications for practice in this area.

National context

Nationally, there has been a growing recognition that many children and young people within the criminal justice system have speech, language and communication needs (SLCN). Bercow (2008) reported that around 7,000 children and young people are involved in the criminal justice system each year, and estimate that around 60% of these have SLCN. Concerns have been raised that most of the interventions aimed at reducing reoffending and rehabilitating young people who have been involved in criminal activity are often verbally mediated. If these young people have SLCN, they may be unable to engage fully with these interventions, and as such their impact may be reduced.

Recently, the Youth Justice Board (YJB, 2013) recommended that YOTs adopt a more holistic approach to assessment, using a system known as 'AssetPlus' which will replace the currently used 'Asset' system which has been in place for over 10 years. Both Asset and AssetPlus are structured assessment tools which aim to identify a young person's difficulties, their circumstances and the risk of re-offending. In particular, with guidance from the Royal College of Speech and Language

Therapists (RCSLT), the new AssetPlus will address the area of SLCN and aim to identify young people with these difficulties. The current Asset system does not include SLCN as part of the assessment process (Games et al., 2012). AssetPlus will be implemented in all YOTs in 2014-2015.

Local context

The YOT described within this PPR is based in a city in the West Midlands which has a population of approximately 250,000 people. This YOT serves the children and young people of the city who have been involved in criminal activity. The YOT is a multi-agency team coordinated by the Local Authority (LA) and overseen by a national body, the YJB. The YOT includes staff from a range of agencies such as education, health, police, fire service, Connexions, probation and social services. YOTs were set up following the 1998 Crime and Disorder Act (HMSO, 1998), with this particular YOT being formed as part of the national pilot. The aim of the YOT is to reduce the risk of offending and re-offending and offer support for those young people up to the age of 18 who have offended.

Within this particular YOT, the managers recognised that their staff will soon be required to assess young people's SLCN once AssetPlus is implemented. As a result of this, they decided that it would be helpful to begin to explore how these needs are identified in young people and ensure that this was part of their practice prior the implementation of AssetPlus. They approached the Specialist Senior EP that supports the YOT and asked for additional support with this. At this point, it was decided that this would be a good opportunity for me, a Trainee EP, to become involved with the YOT and help support this project. Although EPs work fairly closely

with Speech and Language Therapists (SALTs) in other areas of work in the city, such as school-based casework, there appears to be few links between the YOT and SALT.

I began by identifying SLCN screening tools that had been utilised with young offenders in other parts of the country, and then advised the YOT regarding a screening tool that could be used locally to identify the young people who might require additional intervention and/or support for this type of difficulty.

Literature review

My literature review was conducted using the University's online library 'Search' feature, looking for key terms such as 'speech, language and communication needs', 'speech and language difficulties' and 'young offenders'. Research from 2000 onwards was included, to ensure that the literature review reflected only the most current research in this area. Up until 2000, there appears to have been little research conducted in this area (Humber & Snow, 2001). Several papers from the 1990s regarding the use of screening tools were included, as they were widely cited by more recent published literature (Glascoe & Byrne, 1993; Law et al., 1998; Marquardt and Gillam, 1999).

The second part of the literature review focuses on organisational change, with a particular focus on the organisation development (OD) action research model (Senior & Swailes, 2010).

SLCN and young offenders

Bercow (2008) expressed concerns regarding the lack of support for the 60% of young offenders with SLCN; Recommendation 28 of this report stated that support for these young people should be strengthened (p. 11). This review noted that young offenders with SLCN are often not identified, not referred for specialist assessment and intervention from a SALT, and therefore often do not receive the support that they need.

Support for individuals within the criminal justice system with SLCN is vital. Loucks (2007), in a project entitled 'No One Knows' highlighted the high number of adults within the criminal justice system with learning difficulties and learning disabilities (estimated to be between 20-30%) and noted that limited provision or additional support was available for these people. As part of this project, Talbot and Riley (2007) noted that there was no routine screening or assessment for such difficulties at any point in the criminal justice process. Talbot (2010) explored the views of adult prisoners with learning difficulties, who reported that day-to-day they experienced problems with reading and writing, understanding and being understood, following prison rules and discipline, being scared or bullied, daily living skills, and depression and anxiety. Although this project focused mainly on adults within the criminal justice system, it is highly likely that the population of young offenders experience similar difficulties. Sanger et al. (2003) explored the views of a small sample of girls in a 'correctional facility' in the USA and noted that they also expressed feelings of failure in many areas of their lives.

Games et al. (2012) studied the needs of young people in one Youth Offending Service in the UK, where SLCN was identified as a significant risk factor with involvement in crime and where staff within this particular service had little

understanding of SLCN and how to support young people with these needs. Although their sample was small (only 11 children), they found that 90% had SLCN (Games et al., 2012). This is a significant finding, which has been replicated in many other studies across the world where young offenders are reported to have a higher proportion with SLCN (around 60%, Bryan et al., 2007) than the general population (where it is around 10%, Bryan et al., 2007): in the UK, Snowling et al. (2000) reported that young offenders often experience general verbal deficits, problems with language and literacy, and low levels of academic achievement. In Canada, Brownlie et al. (2004) found high rates of SLCN in what they describe as 'conduct disordered and incarcerated youth' (p. 453). In Australia, Snow and Powell (2011) also found that SLCN were over-represented in young offenders within the justice system. Thus, it is likely that all professionals working with young offenders are likely to meet a high number with SLCN.

It is my view that it is important for young offenders with SLCN to receive additional support to address these difficulties, as without it they may be unable to benefit from other interventions, such as anger management programmes, literacy and numeracy courses and other rehabilitation programmes which tend to be verbally mediated. If we are to rehabilitate these young offenders and reduce the risk or re-offending, it is vital that they have equal opportunities to engage with such programmes, with accommodations made for their SLCN. Davies et al. (2004) explored the demands of general offending behaviour programmes and found that the speaking and listening demands tended to be very high, often at GCSE Grade A*-C or higher. However, only 26% of offenders engaged in these programmes had skills at this level (Davies et al., 2004). Bryan (2004) also found that around 40% of young offenders might find it difficult to engage in verbally-mediated interventions. HM Prison Service (2002)

note the importance of literacy and numeracy skills in reducing re-offending, whilst HM Government (2005) state that re-offending can be reduced through improving the skills of offenders and ensuring that they can engage in employment. SLCN should also be addressed so that both young people and adults who offend can develop their other skills and engage with society.

Humber and Snow (2001) found that young offenders' performance was worse on a range of language tasks compared to a control group. They also noted that interventions aimed at supporting young offenders relied on a wide variety of different language skills, including listening, understanding, finding non-literal meanings, processing conversations, formulating their own ideas and experiences into words, and participating in group and individual treatment in socially acceptable ways (Humber & Snow, 2001). Although this study had a small sample of fifteen young offender participants, significant weaknesses in their language skills were found across all tasks compared to a matched sample of young people.

Snow and Powell (2005), this time with a sample of thirty young people, also noted that young offenders with SLCN were likely to experience difficulties in investigative or evidentiary interviews, where they may struggle to understand what is being said to them or express their own views and tell their story. As such, they may implicate themselves in crimes that they have not committed or fail to provide sufficient detail to ensure they are represented fairly. For this reason, it may be beneficial to screen young offenders for SLCN so that additional support can be put into place if necessary, particularly as they are vulnerable young people who may already be at a disadvantage due to unidentified difficulties.

SLCN may often be missed and young people may not be identified as having these needs, perhaps as their difficulties are seen as 'the norm' within that population (Bryan et al., 2007). Snow and Powell (2004) noted that SLCN may often be mistaken for boredom, evasion and resistance to engage. Sanger et al. (2001) studied 67 female young offenders and found that many of these girls had unidentified SLCN. Several reasons as to why these girls' needs had not been identified were put forward, including the possibility that there were other, more obvious difficulties (such as behaviour), that they did not meet criteria to receive additional support (i.e. their 'scores' were below average, but not low enough to warrant a referral), that there was a lack of services available to meet these needs, and because their SLCN were hidden as the girls were able to employ appropriate pragmatic skills when engaging in conversation. The fact that SLCN are often missed is another reason that screening for such difficulties should be routine practice when working with young offenders.

Games et al. (2012) offer a number of criticisms regarding published papers into SLCN and young offenders. For example, Games et al. (2012) note that such studies often rely on very small samples and do not utilise random sampling methods; often a small number of young people are selected by YOT staff, who may purposefully select them due to their apparent SLCN. Similarly, there tends to be high dropout rates if the studies adopt a longitudinal approach and there is often no matched control group. As such, the high number of young offenders with SLCN may be overestimated. Similarly, Games et al. (2012) report that the tests used frequently to assess young offenders speech and language skills are often non-standardised, or when they are standardised, are not for the age group of the sample selected. This may mean that the findings of such studies lack validity and reliability.

Despite these criticisms, a wide range of studies from across the world suggest that both young and adult offenders are more likely to have potentially unidentified SLCN than the general population as a whole.

Why is there a link between offending behaviour and SLCN?

A number of studies have attempted to explore the reasons behind the link between offending behaviour and SLCN. Brownlie et al. (2004) found that boys with SLCN had higher levels of parent-rated delinquency symptoms, and also higher rates of arrests and convictions, compared to a control group. This longitudinal study was carried out in Canada and followed the sample from age 5 up until age 19 years. The dropout rate between the first wave and final wave of the research was 9.2%. However, Brownlie et al. (2004) noted that these non-participants were more likely to have SLCN, be classified as of low socio-economic status, be from single parent families and have lower nonverbal IQ scores. Therefore, they argue that their study may actually *underestimate* the prevalence and impact of SCLN. Although Brownlie et al. (2004) found a link between SLCN and higher rates of arrests and convictions, a correlation is not necessarily indicative of a causal relationship. It could be that SLCN had a negative impact upon the young person's engagement in school, or upon their social functioning, or another variable not investigated in this study, which caused the links with offending behaviour.

Snow and Powell (2008) found that young offenders performed worse on social skills measures than a non-offending control group. As such, it could be argued that it is the underdeveloped social skills of a young person that may lead to offending or antisocial behaviour, rather than these being a direct result of their SLCN.

SLCN have also been associated with unemployment (HM Government, 2005), behavioural difficulties (Brownlie et al., 2004), and mental health difficulties (Sanger et al., 2001) , which may all be linked to offending behaviour. Although the exact causal pathway between SLCN and offending behaviour is difficult to identify, research evidence continues to suggest that there is a link between the two.

YOTs working with SALTs

The Bercow Report (Bercow, 2008) suggested that there was little joint-working between YOTs and SALTs across the UK. It is only fairly recently that this area of work has begun to receive attention. For example, in the YJB (2004) progress report on the delivery of learning and skills, there was no section highlighting the need for supporting young offenders to develop their speech, language and communication skills. However, in 2006, the YJB explored the barriers to engagement in education, employment and training and noted the importance or promoting language development in order to overcome these. The YJB (2008) promote the importance of assessment, identifying individual needs and tailoring interventions to meet these. It has been stated by the YJB that SLCN will be included in this assessment when AssetPlus is implemented in 2014-2015.

Bryan and Gregory (2013) conducted a study in one YOT where a SALT had been working for 3.5 days per week for 12 months, and aimed to explore the views of staff within this team regarding their experiences of working with a SALT. They administered a questionnaire to all staff and carried out eight follow-up telephone interviews to explore the questionnaire findings further. Bryan and Gregory (2013) achieved an 87% response rate and found that the staff who responded were largely positive about working with a SALT and felt that there were many benefits of having

this opportunity. Benefits identified included increasing understanding of the nature of SLCN, positive outcomes for the young people, improvements in working practices and a change in culture (Bryan & Gregory, 2013). Bryan and Gregory (2013) also noted that the delivery of speech and language therapy in youth offending populations is beginning to be explored nationally. Gregory and Bryan (2009) carried out a research project within Leeds YOT, where all young people sentenced to the Intensive Supervision and Surveillance Programme (ISSP) were screened for SLCN, and received additional support from a SALT if required. They found that 65% of those screened had SLCN and 20% were categorised as 'severely delayed' (Gregory & Bryan, 2011). As a result of this project, Gregory and Bryan (2009) recommended that *all* young people involved in the YOT should be screened for SLCN, that all staff involved in the YOT be trained to administer the screening tool and meet the needs of young people with SLCN, and that resources should be adapted for these young people. Nippold (2012) also explored different models of SALT delivery and found that integrated support at all levels of intervention was the favoured approach, as opposed to the traditional model where the young person is withdrawn on a one-to-one basis for half an hour per week.

Despite research that has highlighted the positive outcomes of SALT working closely with YOTs and young offenders, it is only recently that the YJB have recommended this. In the YJB (2004) 'Progress report on delivery of learning and skills', there is no mention of SLCN. YJB (2006) noted that poor language development could act as a barrier to engagement in education, employment and training. It is only in the implementation of the new 'AssetPlus' system that the YJB are recommending that all young offenders are assessed for SLCN.

Screening for SLCN

Although screening young offenders for SLCN has been identified as an area of development for YOTs, there is no widely available screening tool that has been developed for this population (Bryan et al., 2007). A number of different screening tools and assessments have been used in research with this population (Bryan et al., 2007) which highlights the question of whether screening accurately for SLCN is possible and beneficial.

Screening tools in general have been criticised. Glascoe and Byrne (1993) state that 'screening tests are widely used for early identification but few are studied for their accuracy – the percentage of children with and without problems correctly detected' (p. 368). Glascoe and Byrne (1993) recommend that screening tests should detect approximately 80% of children with true difficulties and 90% of those without problems. This raises concern that some screening tools may under- or over-detect children and young people with true difficulties. However, Glascoe (2001) found that children 'over-referred' to specialist services following a range of developmental screening tools were subject to other significant risk factors (such as minority status and low parental education) and performed lower on measures of intelligence, language and academic achievement. Thus, over-referral for these children was not necessarily a negative thing (Glascoe, 2001).

Law et al. (2000), in a systematic review of the literature, explored the feasibility of universal screening for speech and language delay. They studied 45 papers published in this area, and concluded that there was no appropriate tool that could be used universally, with all children, and that many of the screening tools were not particularly sensitive or accurate at identifying children with a true need. However, they found that the likelihood of accurately identifying children with speech and

language delay increased in disadvantaged populations, such as the youth offending population (Law et al., 2000). Therefore, Law et al. (2000) promote the use of screening tools for these 'at risk' populations.

Role for the EP?

When considering the SLCN of young offenders, this may seem to be a key role for SALTs, rather than EPs. However, due to a national shortage in SALTs (Bercow, 2008), I would argue that EPs may be well placed to offer additional support in this area. For example, Games et al. (2012) suggest that EPs could play an important role in designing, planning and evaluating interventions due to their research skills, offering consultancy, advice and support for YOT staff, and raising awareness regarding SLCN. It is important to note here that, nationally, there are only a small number of EPs working with YOTs (Games et al., 2012). Bercow (2008) also suggested that professionals often do not understand SLCN; I would argue that EPs are well positioned within LAs to offer this type of support through training.

Organisational change

As this PPR involves assisting the YOT in implementing a screening tool for SLCN, something which is a new concept for this team, it is helpful to consider this process within an organisational change framework. Senior and Swailes (2010) define an organisation as 'systems comprising elements of formal organisational management and operations, as well as elements of the more informal aspects of organisational life' (p.3). The YOT can be thought of as on organisation in this sense, with a formal organisational structure and operational processes, as well as the more informal aspects such as the culture, politics and leadership which will have an impact upon

the process of change. Senior and Swailes (2010) also state that all organisations have 'goals which act as a glue holding together the various systems used to produce outcomes' (p.4). Again, this relates well to the YOT, who have a variety of different professionals working in different ways to achieve the same goal (i.e. reduce offending and risk of re-offending amongst the young people in the city).

Grundy (1993) proposed three different types of change: smooth incremental change, bumpy incremental change and discontinuous change. This idea appears to make intuitive sense, but was proposed on the basis of observation alone, rather than on any empirical evidence. It may be more helpful to consider change as a 'change spectrum'; the situations that lead to change can vary along a spectrum in terms of complexity and seriousness (Senior & Swailes, 2010). For example, change can be on a small-scale and have limited impact on an organisation, or it can be large-scale and devastating to the organisation's structure and functioning. Paton and McCalman (2000) use the terms 'hard' and 'soft' to describe these changes respectively, whereas Senior and Swailes (2010) use the terms 'difficulties' and 'messes'.

'Difficulties' tend to be smaller scale, less serious, have known timescales and involve only a few people within an organisation; 'messes' tend to be larger scale, more serious, have no set timescales and involve many people within an organisation (Senior & Swailes, 2010). Introducing new working practices, such as in the present project of asking YOT workers to become involved in screening young people for SLCN, can be thought of as 'a messy problem involving soft complexity' (p. 60, Senior & Swailes, 2010). This may be due to a lack of agreement that there is a need for adopting new ways of working, that the impetus for change has come from outside of the organisation, or people within the organisation may feel that their

current way of working and responsibilities may be threatened (Paton & McCalman, 2000).

There are many approaches to planning for and implementing change (Senior & Swailes, 2010). In 'messy' situations, such as the present study, problem ownership, communication, and the participation and commitment of involved individuals are important factors in ensuring change is successful (Senior & Swailes, 2010). The culture of an organisation will also influence the success of change (Ogbonna & Harris, 2002).

With the particular change situation described in this PPR, the idea of 'organisational development', a concept with origins in behavioural science (Cummings & Worley, 2008) is key. Senior and Swailes (2010) define organisational development (OD) as 'a set of values and assumptions about organisations and the people within them that, together with a range of concepts and techniques, are thought useful for bringing about long-term, organisation-wide change' (p.315).

The OD approach to change has several key characteristics, detailed by Senior and Swailes (2010). These are highlighted in Table 1 below, with consideration of how these characteristics relate to the present study of change within the YOT.

Defining characteristic	How this relates to the YOT project
A particular emphasis on processes – the notion of organisational learning	I shall be adopting a collaborative approach and asking the YOT workers to be part of the process of implementing change.
Change over the medium- to long-term, that needs to be sustained over a significant period of time	The YOT will be required to screen all young people for SLCN once AssetPlus has been launched – hence, the change needs to be sustained long-term.
Involves the organisation as a whole as well as its parts	As well as involving the management of the YOT, other key members of staff will be involved in both the piloting and development stages.

Participative; the people within the organisation are significant agents of change	The staff from the YOT will be active participants in the process of change.
Has top management support and involvement	The SLCN screening tool has the support of the Head of YOT and the YOT Operations Manager.
Involves a facilitator who takes on the role of a 'change agent'	I will be taking the role of the facilitator or 'change agent'.
Concentrates on planned change as a process that can adapt to a changing situation	Within the present project, no rigid plan for change was developed; instead, a flexible approach which would take into account the feedback from others was adopted.

Table 1. Defining characteristics of the OD approach (based on p. 316, Senior & Swailes, 2010) and how these relate to the present project.

As Table 1 illustrates, the OD approach seems to be a relevant framework for considering the implementation of the SLCN screening tool within the YOT described in this PPR. Such an approach takes into account all of the individuals within the organisation at all levels, is a relatively long-term process, takes into account the 'messy' nature of the problem at hand and recognises the social influences within the organisation that may affect the change process (Senior & Swailes, 2010).

Many models of organisational change have been developed, with perhaps the first being Lewin (1951) and his 'three phase model' of change (Senior & Swailes, 2010). This model proposes three key phases to any change:

1. Unfreezing – changing people's way of thinking and challenging the status quo.
2. Moving – making the changes.
3. Re-freezing – stabilising or institutionalising the changes.

(Based on Cummings & Worley, 2008.)

This three phrase description of change has common sense appeal, but perhaps does not consider the complex nature of organisations and the factors or systems within them that influence change. Senior and Swailes (2010) propose an alternative OD model that considers change within an action research context; within this model, collaboration between the leaders and facilitators of change is crucial. As 'action research' suggests, the OD model involved a combination of 'research' and 'action': collecting relevant data, feeding back results to those who must take action, collaboratively discussing the data to formulate an action plan, and taking action (p.326, Senior & Swailes, 2010). Figure 1 below highlights the OD action research model and the processes involved in bringing about change.

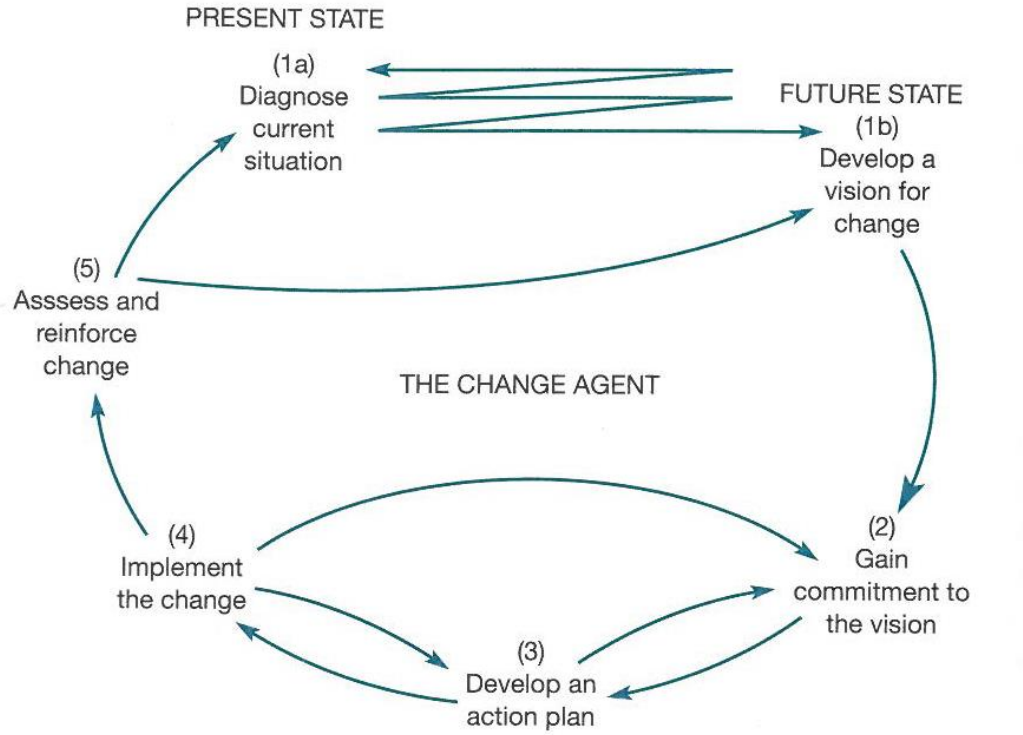


Figure 1. The OD action research model for change (Senior & Swailes, 2010)

As Figure 1 highlights, OD can be thought of as a cyclical process, where each component may also form cycles of activity within each stage. There is also the opportunity to return to previous stages of the model, as indicated by the range of

arrows. The stages of this model will be considered in turn (based on Senior & Swailes, 2010):

- **The Change Agent**: This individual plays a key role in bringing about change, and is placed at the centre of the model for this reason.

- **Stages 1a and 1b**: These two processes, diagnosing the current situation and developing a vision for change, are intertwined, and both are crucial at the start of the change process and often occur in parallel.

- **Stage 2**: This stage involves gaining commitment to the vision for change of all involved individuals within the organisation.

- **Stage 3**: This stage involves developing an action plan for change, often guided by the 'change agent', but also sharing responsibility for change between different members of the organisation. At this stage, it is important to consider the type of change required and at what level in the organisation it should take place.

- **Stage 4**: Change is implemented at this stage, through a variety of possible techniques or methods.

- **Stage 5**: This could be thought of as the 'evaluation stage', where the change is assessed and reinforced.

Research questions

The literature review led to the development of the following research questions:

1) Can the organisational development (OD) action research model be applied to the process of increasing the capacity of YOT workers to identify speech, language and communication needs (SLCN)?
2) Does the application of the OD action research model lead to positive outcomes regarding increasing the capacity of YOT workers to screen young offenders for SLCN?

Methodology

This PPR aims to describe the process of increasing the capacity of YOT worker to screen young people for SLCN using the OD action research model (Senior & Swailes, 2010). I will outline my ontological and epistemological stance, followed by how the OD action research model (Senior & Swailes, 2010) was used as a framework to guide the project. Ethical issues will also be considered.

Ontology and epistemology

Ontology is concerned with what knowledge exists and how it exists (Goodley & Smailes, 2011). I shall be taking an interpretivist approach, which suggests that reality is socially constructed and meaning is attached to the world by the individuals who interact with it (Robson, 2002). The real life working of an organisation has been described as socially constructed (Bate, Khan & Pyle, 2000).

Epistemology is concerned with how we know what exists (Goodley & Smailes, 2011). An action research model, such as the OD model that will be utilised here, suggests that human knowledge is socially constructed and value-laden (Robson, 2002). Within this PPR, I aim to seek an understanding of organisational change

within a particular context through being an active participant in the change process, and through understanding and interpreting the social constructions or views of the other individuals involved in the change process.

The OD action research model

The OD action research model (Senior & Swailes, 2010), as shown in Figure 1, was used as a framework to guide the project. Table 2 highlights the key actions undertaken at each stage of the model:

Stage of OD action research model	Actions undertaken
1a) Diagnose current situation	Consultation with YOT EP, Head of YOT and YOT Operations manager to gain a better understanding of the YOT and its processes. Consultation with SALT regarding the use of screening tools for SLCN and identifying young people with these needs. YOT workers currently gather a range of information regarding a young person's educational history, but do not routinely screen for SLCN. Exploration of what other YOTs in the UK have done (if anything) regarding screening for/supporting young people with SLCN. Exploration of the vast amount of literature suggesting that there is a link between SLCN and offending behaviour in both adults and young people.
1b) Develop a vision for change	YJB recommending that YOTs screen young people for SLCN. This will be mandatory when AssetPlus is rolled out in 2014-2015. Consultation with Head of YOT and YOT Operations Manager regarding the need for change and the idea that I would

	support them in identifying and implementing a suitable screening tool for YOT workers to use to identify SLCN in their young people.
2) Gain commitment to the vision and the need for change	Head of YOT and YOT Operations Manager were committed to supporting the project, as they recognised that they would be asked to screen young people for SLCN once AssetPlus was implemented, and were keen to get a 'head start' at this compared to YOTs in neighbouring LAs. Asked for volunteers from the team of 14 case managers at YOT who would be interested in being involved in the project. Met with the 3 case managers who had put themselves forward, and explained why there was a need for change.
3) Develop an action plan	The 3 case managers agreed to take part in a pilot of two screening tools that had been used in other YOTs in the UK. They agreed to complete a short evaluation once they had trialled the screening tools with at least one young person.
4) Implement the change	Within 4 weeks, the 3 case managers trialled the screening tools with at least one young person and completed the evaluation form.
5) Assess and reinforce the change	Meeting with the case managers and the YOT Operations Manager to share feedback from the evaluations. A further meeting has been planned to feedback the findings from the project with all of the case managers. It is hoped that more case managers will agree to trial the screening tool, and participate in discussions regarding which parts of the tool could be used in their day-to-day practice.

Table 2. Actions undertaken at each stage of the OD action research model (Senior & Swailes, 2010).

The research tools

At Stage 3 of the action research model and through the initial literature review, two screening tools were identified that had been used by two other YOTs within the UK. Both Leeds (Gregory & Bryan, 2009) and Ealing (Burrows & Yiga, 2012) YOTs had been involved in a project where a SALT had worked with the YOT to support the identification of young people with SLCN. The Leeds project had involved screening all young people sentenced to the ISSP for SLCN, and used a range of tools including a self-assessment questionnaire, a section of a standardised text, and an observation of communication (Gregory & Bryan, 2009). In Ealing, a similar process was used and the benefits of therapy for SLCN was explored; a range of screening tools were used including a narrative task, a deduction task, an observation of communication and self-report questionnaires (Burrows & Yiga, 2012). The observation of communication and the self-report questionnaires used were the same in each project. After examining these two screening tools, I felt that they would be useful for use in the present project: they appeared relatively easy to understand and administer for staff who were not used to screening for SLCN, and they did not need to be administered by a qualified SALT (as a standardised test would be).

Marquardt and Gillam (1999) discussed the utility of screening tools and assessments for language difficulties; they expressed concerns regarding a reliance on formal tests, which led to communication being assessed in unnatural environments, and advocated for a more natural approach. Therefore, I felt that an observation of communication, within a more natural environment, was desirable.

I also wanted to include a self-report measure, as they would allow young people to 'provide meaning to their experiences' (p. 509, Bryan et al., 2007). Bryan et al. (2007) also expressed concerns regarding more formal tests of language being used

with young offenders, as they felt that the norms may not reflect the performance of these young people, who may not have engaged in education nor had the same social experiences as their non-offending peers. Therefore, I felt it was important to include some sort of self-report measure that would allow the young person to express their views.

The observation of communication which I decided to use as the first part of the screening tool was taken from Gregory and Bryan (2009): the Broadmoor Observation of Communication (see Appendix 1), so-called as it was based on the initial assessment used at Broadmoor Hospital, but used in the projects in Leeds and Ealing described above. This tool involves a key worker (the case manager, in this project) observing a young person's communication and rating them on a scale of 0-5 for different areas of communication. A range and total score can then be calculated for each young person. This tool accurately identified young people with SLCN in both the Leeds and Ealing projects (Gregory & Bryan, 2009; Burrows & Yiga, 2012).

The self-report measures were also used in both of these projects (Gregory & Bryan, 2009; Burrows & Yiga, 2012). The self-report measures included a questionnaire for the key worker to complete and a questionnaire for the young person to complete (with support from the key worker) (see Appendix 2). The questionnaires involve a range of questions, which the key worker/young person is required to answer with yes/sometimes/no responses. The reason for asking the key worker to complete a questionnaire was an attempt to reduce the risk of inaccurate self-reporting by the young person (Gregory & Bryan, 2009).

As part of the action plan (Stage 3 of the model), I also felt it would be useful for the case managers to offer some feedback on these screening tools. This was done to

promote a collaborative approach: I was providing them with the tools, but was willing to gain their feedback and make changes if desired as they would be the workers who would be required to use the tools on a day-to-day basis. It was felt that this evaluation would be helpful during Stage 5 of the OD action research model (Senior & Swailes, 2010), as it would enable the case managers and I to assess the utility of the screening tools. Senior & Swailes (2010) suggest a range of methods for gaining feedback during various stages in the OD process, including surveys. I decided to design an evaluation survey to assess the utility of the screening tools and also to explore the attitudes of the case managers to screening young people for SLCN. A short evaluation form (see Appendix 3) was developed (following the principles outline by Bryman, 2008) using a range of rating scales and open-ended questions to elicit the case workers' views and opinions. It was hoped that the responses to the evaluation forms would 'help stimulate what is working and what is not and should result in modification to the action plan or the way it is being implemented (p. 349, Senior & Swailes, 2010).

Ethical considerations

The research project was conducted in line with the British Psychological Society's (BPS) Code of Human Research Ethics (2010). A number of ethical issues were considered during the action research process:

- Risks: No significant risks were identified during the planning stages of this research. However, support would be offered to YOT workers if they felt uncomfortable about using the SLCN screening tool or if they questioned their own practice in a negative light.

- Consent: The YOT workers gave verbal consent to take part in the project. Verbal consent was also obtained from the young people with whom the screening tool was trialled. The young people were also informed that their details or scores on the screening tool would not be shared with the researcher, as it was with the evaluation of the process of using the tool with which the researcher was concerned.
- Confidentiality: The YOT workers were informed in writing that their responses on the evaluation tools would remain anonymous. No information regarding the young people was recorded.
- Debriefing: As part of the action research process, the YOT workers who had volunteered to take part in the project received feedback and had the opportunity to express their views regarding the SLCN screening tool at a joint meeting that was held after they had had the opportunity to trial the tool.

Findings

The findings from the evaluation form used to inform Stage 5 of the OD action research model will be presented in this section. Reflections on the use of this model are presented in the discussion.

The case managers were asked to rate each part of the screening tool on a scale of 0-10 for ease of use. The mean of their responses is shown in Figure 2.

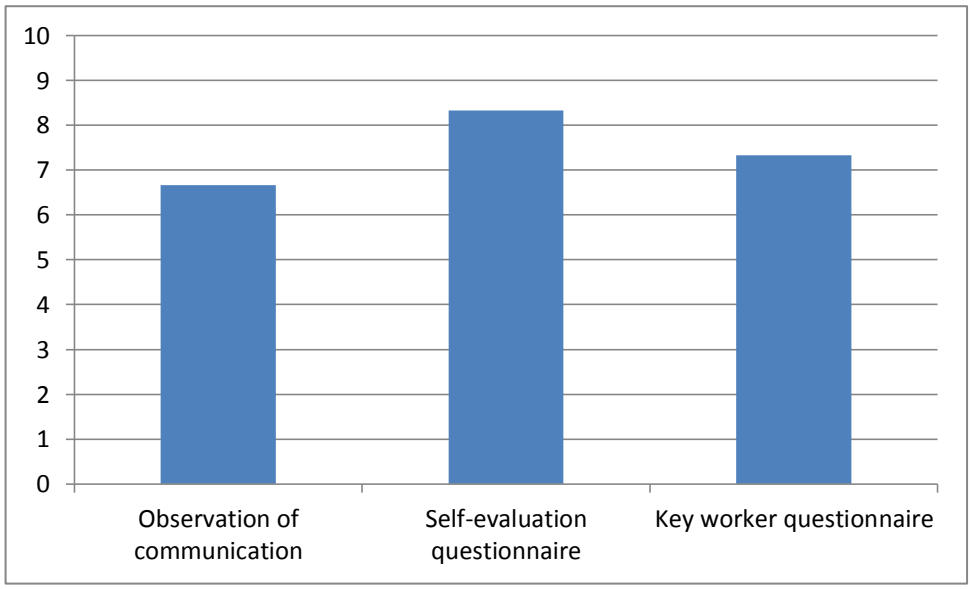


Figure 2. The mean ratings for 'ease of use' for each part of the screening tool.

This suggests that the case managers, on average, found the self-evaluation questionnaire and the key worker questionnaire easier to use than the observation of communication.

Figure 3 shows the mean ratings for practicality of use (i.e. how practical it would be to use these routinely as part of their assessments) for each part of the screening tool.

Figure 3. The mean ratings for 'practicality' for each part of the screening tool.

This suggests that, on average, the case managers thought that the two questionnaires would be more practical to use regularly than the observation of communication.

Figure 4 shows the mean ratings for usefulness (i.e. how useful was the information provided by the tool?) for each part of the screening tool.

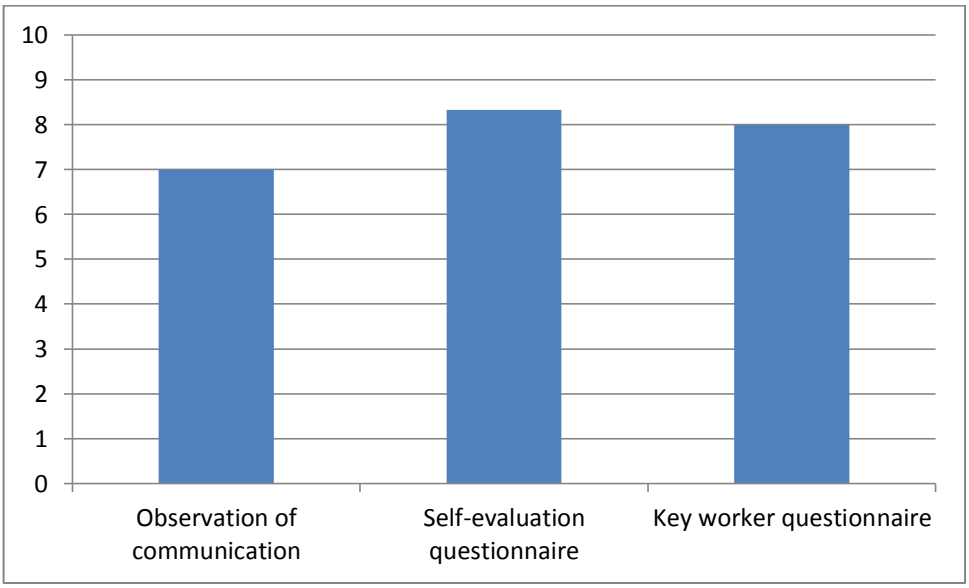


Figure 4. The mean ratings for 'usefulness' for each part of the screening tool.

This suggests that the case managers, on average, thought the information provided by the two questionnaires was slightly more useful than the information provided by the observation of communication.

Due to only having the views of three case managers, it has been difficult to use a rigorous form of analysis on the qualitative responses within the questionnaires. Therefore, rather than attempting to identify themes within the small data set, the comments that the case managers gave regarding each part of the tool are recorded verbatim in Table 3 below.

Part of screening tool	Comments
Observation of communication	It was a straightforward document. Some young people would struggle with expressing themselves. It was a little hard as the sessions I completed were structured and not always natural conversation to observe these areas. Useful tool when reflecting after a session but difficult to complete during. Very useful to gain the outcome of this assessment.
Self-evaluation questionnaire	Young person struggled with it at times. I think it might be more suited to some young people than others. It has enabled me to think more about the methods I use to engage young people. It's helpful to be able to compare my perception of the young person with how they see themselves. Went well with the young person I chose – some may struggle with being 'self-aware'. Can easily be completed as an initial document. Useful to compare to my own assessment.
Key worker questionnaire	Easier to apply to sessions than the previous tool. Useful to reflect on this and how we can help young person understand more. Easy to use – enabled me to reflect on the ease or lack of ease in which the young person expressed themselves. It would be possible to use it in most cases. Helps engagement.

Table 3. Case managers' comments regarding each part of the screening tool.

Table 3 suggests that the case managers appeared to prefer the two questionnaires, rather than the observation tool. They found the questionnaires easier to use with the young people and felt they could be used with most young people. They also seemed to like the opportunity to compare their own perceptions with the young person's. The observation of communication was viewed slightly less favourably. In particular, one case manager commented that it might be difficult to observe a young person's communication in a natural setting due to the way that their sessions were structured.

Table 4 highlights some of the comments made by the case managers regarding the benefits and impact of using the screening tools, and what they would change.

	Comments
Benefits?	Help to identify ways of engaging the young people. Recognising barriers to communication/ Provides insight into possible reasons behind communication issues. It aids engagement. Better able to devise and target interventions.
Impact?	Highlighted the need to be aware of how we communicate, whether we are understood and what difficulties young people have. It enabled me to reflect on issues of body language and how this is a strong aspect of communication. Prompted thought.
Changes?	The self-evaluation may be hard for younger children. The observation of communication is difficult to apply to such a 'forced' scenario – especially if you have just met the child. Adapt to suit the age of the child.

	It seemed a bit clunky at times and it was difficult to engage the young person.

Table 4. Case managers' comments from the questionnaires regarding the benefits and impact of screening young people for SLCN and any changes that they would make to the tools.

These comments give an idea of the case managers' views regarding using the screening tools. These comments will be given further consideration in the discussion.

Discussion

The findings highlighted above suggest that the OD action research model (Senior & Swailes, 2010) may be a useful approach to implementing change within an organisation, such as increasing the capacity of one YOT's workers to identify young people with SLCN. Each of the research questions will be considered in turn.

1) *Can the organisational development (OD) action research model be applied to the process of increasing the capacity of YOT workers to identify speech, language and communication needs (SLCN)?*

The OD action research model (Senior & Swailes, 2010) appeared to be a good framework for implementing change within an organisation, such as the YOT. The different stages of the model appeared well suited to the change that I wished to implement (i.e. increasing the capacity of YOT workers to identify SLCN in the young people they work with). However, there were a number of issues encountered that may mean that the change is not sustained or developed further within the organisation.

Stages 1a and 1b, which involved diagnosing the current situation and developing a vision for change, provided a good starting point for the project; these stages ensured that I developed a good understanding of the current situation within the YOT and their processes (including the fact that they did not routinely screen young people for SLCN) and developed a clear vision for change based on evidence in the research literature and the guidance from the YJB, including the forthcoming implementation of the AssetPlus system.

Stage 2 was perhaps the stage of the model where I could have done more to ensure a commitment to the change that I wished to support the YOT to implement. I felt that the Head of YOT and YOT Operations Manager were committed to the change and wished to support the implementation of the screening tool. However, due to a combination of time constraints and high workloads of the YOT case managers, it was not possible to work closely with them to develop this commitment to the vision for change. As such, only three of a possible fourteen case managers volunteered to take part in the project. There were also delays in these case managers providing feedback regarding the screening tool, suggesting that they did not see the project as a priority and were not necessarily committed to the vision for change, despite encouragement from their senior managers. Another issue that may have influenced the strength of the vision for change was that it may be difficult for an outsider, such as myself, to understand an organisation, such as the YOT, and the people within it (Stacey, 2010). For this reason, I may have misunderstood the responsibilities of the case managers, for example, and may have asked them to become involved in something which they did not perceive as part of their role, such as screening young

people for SLCN. Related to this is the idea that the individuals' interpretations of the change determines their response (Mason, 2007); if the case managers did not view screening for SLCN as part of their role, they may have felt that the change I was trying to implement did not or should not involve them.

The issues experienced at Stage 2 of the model had an impact on the latter stages. For example, at Stage 3 I worked closely with the Head of YOT and YOT Operations Manager to develop an action plan. However, the case managers were not involved directly with this stage, and instead had the action plan almost imposed upon them. It may have been helpful if the case managers had been more involved at this stage, as Senior and Swailes (2010) suggest that change is most successful when all of the individuals involved are part of the decision-making process. At Stage 4, the case managers trialled the screening tool and provided feedback which helped at Stage 5 (assessing and reinforcing the change). However, as only three case managers were involved in the trialling stage, only limited feedback regarding the suitability and utility of the screening tool was obtained. For this reason, it has been difficult to determine whether the two elements of the screening tool could be used in the day-to-day work of the YOT. As the Head of YOT and YOT Operations Manager are keen to increase the capacity of their workers to screen young people for SLCN, it is likely that I will continue to be involved in this project. My plan would be to return to Stage 2 of the model and increase the case managers commitment to the vision for change. I plan to do this by attending one of their regular team meetings and, with the support of the YOT Operations Manager, discussing the prevalence of SLCN amongst young offenders and the forthcoming changes regarding identifying these needs when AssetPlus is implemented.

It is also important to consider why the OD action research model (Senior & Swailes, 2010) may not have been entirely successful in this case. For example, Senior & Swailes (2010) suggest that successful organisations develop internal forces for stability, and that these forces can produce resistance to future changes. In an organisation that perceives itself to be successful, it could be that the people within it do not see a need for change and so are resistant towards it. It could be helpful to spend more time working with these individuals to reduce this resistance and create forces that will support future change.

It may also be useful to consider limitations within my role or competency as the 'change agent' within the OD action research process. Senior and Swailes (2010) outline key competences of an effective change agent, some of which I may not have demonstrated. For example, although I specified goals and was flexible in my approach, it may be that as I did not know the case managers my approach lacked sensitivity to their needs and current workloads. I also did not have sufficient opportunity to invest time in team-building, or establishing a working group to look at SLCN. I felt that my motivation and enthusiasm, as well as my communication skills, were both strengths of my approach as a change agent, but this may not have been sufficient to bring about long-term change within the YOT. Issues around scholar-practitioner engagement may also have reduced the effectiveness of the change process (Senior & Swailes, 2010); it could be that the case managers (practitioners) saw my role as a 'scholar' as being very different from their role, and therefore felt that I had little understanding of their day-to-day work and the realities of working within a YOT.

General criticisms of the OD action research model (Senior & Swailes, 2010) also need to be considered. For example, it could be argued that the model does not address the realities of bringing about change and the complex contexts of organisations (Parkes, 2008). Within the present project, it may be that the idea for change was supported by the senior managers, but was not supported by the case managers within the organisation who were key players in supporting the change. The case managers may have felt that the change was being imposed upon them, and may have had little commitment to the project as a result. Other models of change, such as the Research and Development in Organisations (RADIO) Model (Timmins et al., 2003) or an Appreciative Inquiry (AI) (Cooperrider & Whitney, 2005) approach may have led to different outcomes if they had been utilised within the present project. The RADIO Model (Timmins et al., 2003) would have encouraged further work at the earlier stages of change, such as clarifying organisational and cultural issues and identifying stakeholders, that may have led to a greater commitment to change from all individuals within the organisation. An AI approach (Cooperrider & Whitney, 2005) may have taken a more positive approach, and focused on the positives within the organisation, rather than considering the deficits and difficulties regarding change. Such an approach may have been more in line with the epistemological stance of social constructionism, as it would focus on the social interactions within the organisation and encourages individuals to 'co-author' the narratives that make up the organisation (Dunlap, 2008).

2) *Does the application of the OD action research model lead to positive outcomes regarding increasing the capacity of YOT workers to screen young offenders for SLCN?*

Due to the small number of case managers who volunteered to trial the tool, it is difficult to determine whether the OD action research model has led to positive outcomes regarding increasing the capacity of YOT workers to screen young people for SLCN. The case managers' responses suggested that the process of trialling the screening tool may have changed their perceptions regarding the importance of screening young people for SLCN. This is similar to the study conducted by Bryan and Gregory (2013) who found that focusing on this area led to YOT workers changing their views regarding the importance of identifying SLCN and recognising the impact that these needs can have when working with these young people.

The present project may have increased the capacity of YOT workers to identify young people with SLCN by identifying potentially useful and practical screening tools that they could use as part of their day-to-day work. In particular, the case managers' feedback suggested that the self-evaluation and key worker questionnaires could be practical to use, could provide useful information and were relatively easy to use. It would be hoped that with further support from myself as the 'change agent', more of the case managers could be encouraged to trial the tools in the future to determine whether they could be implemented in their regular practice. The idea of using a self-report measure, such as the self-evaluation questionnaire may be positive, as Bryan et al. (2007) note that the majority of more formal tests of language may be unsuitable for use with young offenders, as their norms may not

reflect the performance of pupils who may not have engaged in education or had social experiences (p. 509). Therefore, self-report measures may be more appropriate with this population.

One of the case managers noted that the screening tool may not provide an accurate description of a young person's communication skills if they are shy, or if they have only just met the case manager. Thus, to ensure that the case managers are able to identify SLCN accurately within the young people they are working with, it may helpful to consider how many sessions should be spent on rapport-building and getting to know the young person before attempting to use the screening tool. If the screening tool was used at too early a stage, it may be that the young person is identified as having SLCN, when in fact they are shy or a reluctant communicator with unfamiliar people.

It is also important to note that other studies that have looked at increasing the capacity of YOTs to identify SLCN in young people have directly employed a SALT to work within their team (e.g. Bryan, 2004; Bryan et al., 2007). Although the present findings suggest that the case managers were able to use the screening tools effectively, the validity of screening for SLCN by someone other than a SALT could be questioned (Bryan, 2004).

The findings from the present study highlighted some potential future actions. For example, the YOT workers felt that is was useful to identify young people with SLCN, but did not feel confident in knowing how best to support a young person if they were identified as having needs in this area. In conjunction with a SALT, I am hoping to

develop a set of factsheets about a range of SLCN (e.g. expressive language difficulties, receptive language difficulties, speech difficulties) with ideas of how the YOT worker could support a person with those needs, including ideas for intervention and things to consider when working with that young person. This may also involve some short training sessions, where the factsheets will be presented and there will be an opportunity for further discussion.

Some thought has also been given to what to do with information regarding a young person's SLCN. Further work may explore designing a speech and communication plan for each young person and identifying when a referral to a qualified SALT may be required (Tommerdahl, 2009). Future research could also explore the impact of SLCN within court and legal settings (Humber & Snow, 2001) and whether a screening tool could be developed that includes the views of the young person's parent or carer (Law et al., 1998).

Implications for practice

YOTs and YOT workers

The present project highlights a range of implications for the practice of YOTs and YOT workers. As all YOTs will be required to screen all young people for SLCN, the tools used within the present project, and in Leeds (Gregory & Bryan, 2009) and Ealing (Burrows & Yiga, 2012) may prove useful. Similarly, adopting a model, such as the OD action research model (Senior & Swailes, 2010) may be helpful in bringing about this change. However, it is important to remember that 'even in the same sector in similarly-sized organisations of similar age attempting the same change, there will be big differences in the experiences and attitudes of the people involved

and in their social relationships and the resources available to support change' (p. 52, Senior & Swailes, 2010), and so the findings from the present project must be generalised with caution.

YOTs should also give further consideration to the prevalence of SLCN amongst the population they serve, and explore the impact that this will have on the potential success or benefits of any verbally-mediated interventions aimed at reducing the risk of re-offending (Bryan, 2004). As well as implementing routine screening of all young offenders, it may also be useful for YOT workers to receive additional training regarding SLCN and adapt materials, resources and information to address these additional needs (Gregory & Bryan, 2009).

EPs

The findings also have implications for the practice of EPs. For example, they may be well-placed to design, plan and evaluate interventions for young people with SLCN due to their research skills, offer consultancy and advice to YOTs and their workers, and raise awareness of the prevalence and potential impact of SLCN amongst the population of young offenders (Games et al., 2012).

SALTs

Although this project did not explore the role of the SALT, the findings may have implications for this professional group. For example, it may be beneficial for SALTs to play a more active role in supporting YOTs and the young people they work with, and offering targeted interventions for this vulnerable group (Bryan & Gregory, 2013).

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Appendix 1: Observation of Communication
(developed by Bryan, 1998)

0 = inappropriate 5 = appropriate

Communication Parameter	0	1	2	3	4	5	Comments
Non-verbal							
Gesture							
Facial expression							
Eye contact							
Posture							
Proximity							
Listening (attention)							
Speech							
Intelligibility							
Articulation							
Rate							
Volume							
Resonance							
Intonation							
Fluency							
Voice quality							
Language							
Initiation							
Topic maintenance							
Topic changes							
Response time							
Content							
Assumptions							
Assertive routines							
Supportive routines							
Inference							
Humour							

A maximum score of 120 indicates no difficulty
119-97 indicates a mild difficulty
96-49 indicates a moderate difficulty
48 and below <u>OR</u> a score of 0-2 in any one area indicates a severe difficulty

Observation of Communication: Annotated version
(developed by Bryan, 1998)

0 = inappropriate 5 = appropriate

Communication Parameter	**0**	**1**	**2**	**3**	**4**	**5**
Non-verbal						
Gesture	None/highly exaggerated……..Appropriate natural gestures					
Facial expression	Blank/exaggerated expression....Appropriate smiling/frowning					
Eye contact	Staring/avoidance of eye gaze….Relaxed natural eye contact					
Posture	Hunched up/over exaggerated.....Appropriate body language					
Proximity	Too close/too distance…....Comfortable distance for situation					
Listening (attention)	Complete lack of attention……Good listening/attention					
Speech						
Intelligibility	Impossible to understand.…Clear easy to understand speech					
Articulation	Laboured/clumsy speech……....Relaxed clear easy speech					
Rate	Much too fast/slow……..…Appropriate speed for the situation					
Volume	Inaudible/extremely loud……..Appropriate volume					
Resonance	Very nasal/nasal air escape…….……...Normal nasality					
Intonation	Flat/monotone voice…...….Voice rising & falling appropriately					
Fluency	Stammering/hesitant…….....Smooth non-hesitant speech					
Voice quality	Husky/hoarse/strained voice……...Clear unrestrained voice					
Language						
Initiation	Never starts conversation....Starts conversation appropriately					
Topic maintenance	Completely unable to maintain topic……Stays on topic					
Topic changes	Constant changing of topic……..Moving on when appropriate					
Response time	No response/very slow……..…Answering straightaway					
Content	Irrelevant/inappropriate content……..Appropriate content					
Assumptions	Incorrect assumptions……....Aware of listener's knowledge					
Assertive routines	Constantly interrupts/never speaks……Voices opinion clearly					
Supportive routines	No sign of listening/empathy..Clear signs of listening/empathy					
Inference	Literal understanding only..Understands implied/unstated info					
Humour	No understanding of humour…Shares jokes/funny comments					

Appendix 2: Key worker questionnaire (based on Gregory & Bryan, 2009)

Name of young person:_____ DOB:_____ Completed by: _____
Date:_____

Question	Please select one of the options based on your knowledge of the young person:			Additional comments
1. When the young person (YP) is talking to you, how much do you understand?	You understand them most of the time	You understand about half the time	You hardly ever understand	
2. What do you think about the sound of the YP's voice?	Fine most of the time – no problems	About half the time ok and half the time have problems	Really don't like it / really worried about it	
3. Can the YP get their words out when they are talking?	Yes – most of the time	Yes – about half the time	Has problems getting words out most of the time	
4. When you are talking to the YP, how much do you think they understand?	They understand most of the time	They understand about half of what you say	They hardly ever understand	
5. Does the YP sometimes need more time to understand?	Usually don't need more time	Need more time about half the time	Need more time most of the time	
6. Can the YP tell people what they want or need?	Yes - fine most of the time	Problematic about half of the time	Problematic most of the time	

7. Can the YP tell somebody how they feel?	Yes - fine most of the time	Problematic about half of the time	Problematic most of the time	
8. When the YP is talking to somebody, do you think they take turns equally? Or does somebody do more of the talking?	The turns are equal most of the time	The turns are equal about half of the time	One person does most talking (please specify who)	
9. How does the YP find talking to staff?	Fine most of the time	Problematic about half of the time	Problematic most of the time	
10. How does the YP find talking to their friends/peers?	Fine most of the time	Problematic about half of the time	Problematic most of the time	
11. Is the YP usually able to find the right words to explain what they want to say?	Can find the right words most of the time	Can find the right words about half of the time	Can't find the right words most of the time	
12. Does the YP remember everything they want to say?	Remember everything most of the time	Remember everything about half of the time	Can't remember everything most of the time	
13. Does the YP find explaining something complicated?	Fine most of the time	Problematic about half of the time	Problematic most of the time	

14. Do you think the YP had any problems with their speech or communication?	No / has some difficulties which cause only minor problems	Has difficulties which cause problems about half of the time	Yes / has lots of difficulties which cause lots of problems	
15. How does the YP find following routines or remembering appointments?	Can follow routines / remember appointments most of the time	Can follow routines / remember appointments about half of the time	Finds it difficult to follow routines / remember appointments most of the time	

Scoring: Column 1 response = 1, Column 2 = 0.5, Column 3 = 0. Maximum score = 15. **Score = ___**

Self-evaluation questionnaire (based on Gregory & Bryan, 2009)

Name of young person:_____ DOB:_____ Completed by the young person.

Question (to be read by keyworker)	Please select one of the options:			Additional comments
1. When you are talking to somebody, do you think they understand?	They understand most of the time	They understand about half the time	They hardly ever understand	
2. What do you think about the sound of your voice?	Fine most of the time – no problems	About half the time ok and half the time have problems	Really don't like it / really worried about it	
3. Can you get your words out when you are talking?	Yes – most of the time	Yes – about half the time	Have problems getting words out most of the time	
4. When somebody is talking to you, how much do you understand?	Understand most of the time	Understand about half of what you say	Hardly ever understand	
5. Do you sometimes need more time to understand?	Usually don't need more time	Need more time about half the time	Need more time most of the time	
6. Can you tell people what you want or need?	Yes - fine most of the time	Difficult about half of the time	Difficult most of the time	

7. Can you tell somebody how you feel?	Yes - fine most of the time	Difficult about half of the time	Difficult most of the time	
8. When you are talking to somebody, do you think you take turns equally? Or does somebody do more of the talking?	The turns are equal most of the time	The turns are equal about half of the time	One person does most talking (please specify who)	
9. How do you find talking to staff?	Fine most of the time	Difficult about half of the time	Difficult most of the time	
10. How do you find talking to your friends?	Fine most of the time	Difficult about half of the time	Difficult most of the time	
11. Are you usually able to find the right words to explain what you want to say?	Can find the right words most of the time	Can find the right words about half of the time	Can't find the right words most of the time	
12. Does you remember everything you want to say?	Remember everything most of the time	Remember everything about half of the time	Can't remember everything most of the time	
13. Do you find explaining something complicated?	Fine most of the time	Difficult about half of the time	Difficult most of the time	

14. Do you think you have any problems with your speech or communication?	No / have some difficulties which cause only minor problems	Have difficulties which cause problems about half of the time	Yes / have lots of difficulties which cause lots of problems	
15. How do you find following routines or remembering appointments?	Can follow routines / remember appointments most of the time	Can follow routines / remember appointments about half of the time	Finds it difficult to follow routines / remember appointments most of the time	

Scoring: Column 1 response = 1, Column 2 = 0.5, Column 3 = 0. Maximum score = 15. **Score = ___**

Appendix 3: Screening Tool Evaluation

Dear Staff Member,

As part of my University coursework, I am undertaking an evaluation of the speech and language screening tools that you have recently been asked to trial. I would really appreciate it if you could answer the following questions and return the form to Pete Madden no later than Friday 23rd May.

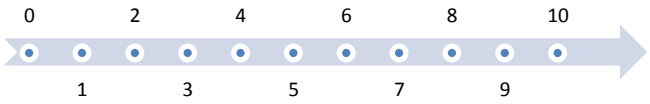
Nobody else will have access to you responses and the findings in my report will be anonymous.

Your name:

Your role:

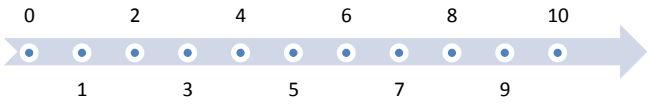
On a scale of 0-10, please rate the following in relation to the **Observation of Communication**:

Ease of use



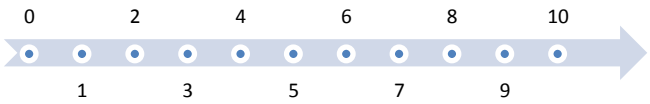
Any comments?

Practicality (i.e. how practical would it be to use this routinely as part of your assessments?)



Any comments?

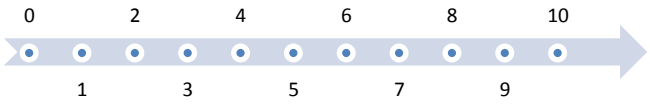
Usefulness (i.e. how useful is the information provided by the tool?)



Any comments?

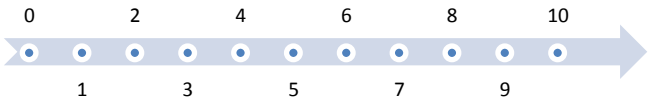
On a scale of 0-10, please rate the following in relation to the **Key worker Questionnaire**:

Ease of use



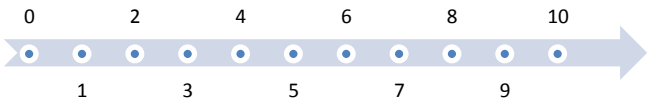
Any comments?

Practicality (i.e. how practical would it be to use this routinely as part of your assessments?)



Any comments?

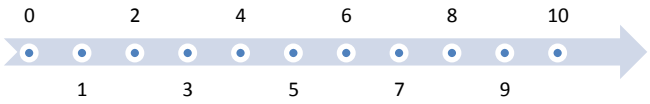
Usefulness (i.e. how useful is the information provided by the tool?)



Any comments?

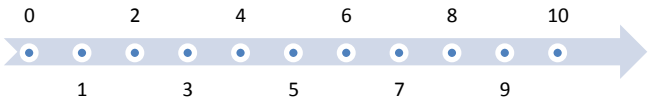
On a scale of 0-10, please rate the following in relation to the **Self-evaluation questionnaire** (completed by the young person):

Ease of use



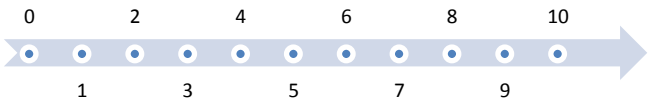
Any comments?

Practicality (i.e. how practical would it be to use this routinely as part of your assessments?)



Any comments?

Usefulness (i.e. how useful is the information provided by the tool?)



Any comments?

In your view:
1) What are the benefits (if any) of screening young people for speech, language and communication needs?
2) Are there any parts of the screening tool that you would change? If so, what would you change?
3) What impact (either on yourself or on the young person) do you feel that using the screening tool has had?
4) Any other comments?

Thank you for your time.