CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	Evaluation of the in-school and early years therapy support demonstration project
Authors	Lynch, Helen;Ring, Emer;Boyle, Bryan;Moore, Alice;O'Toole, Ciara;O'Sullivan, Lisha;Brophy, Therese;Frizelle, Pauline;Horgan, Deirdre;O'Sullivan, Deirdre
Publication date	2020-10-01
Original Citation	Lynch, H., Ring, E., Boyle, B., Moore, A., O'Toole, C., O'Sullivan, L., Brophy, T., Frizelle, P., Horgan, D., O'Sullivan, D. (2021) Evaluation of the In-School and Early Years Therapy Support Demonstration Project, Research Report No. 28, Trim, Meath: National Council for Special Education.
Type of publication	Report
Link to publisher's version	https://ncse.ie/wp-content/uploads/2020/11/Demo-project-evaluation-fInal-for-web-upload.pdf, https://ncse.ie/
Rights	© NCSE 2020
Download date	2026-10-30 07:14:10
Item downloaded from	https://hdl.handle.net/10468/11627



University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

An Chomhairle Náisiúnta um Oideachas Speisialta
National Council for Special Education

Evaluation of In-School and Early Years Therapy Support Demonstration Project

Authors: Helen Lynch, Emer Ring, Bryan Boyle, Alice Moore, Ciara O'Toole, Lisha O'Sullivan, Therese Brophy, Pauline Frizelle, Deirdre Horgan, Dan O'Sullivan

RESEARCH REPORT NO. 28

An Chomhairle Náisiúnta um Oideachas Speisialta
National Council for Special Education

Evaluation of In-School and Early Years Therapy Support Demonstration Project

Authors: Helen Lynch, Emer Ring, Bryan Boyle, Alice Moore, Ciara O'Toole, Lisha O'Sullivan, Therese Brophy, Pauline Frizelle, Deirdre Horgan, Dan O'Sullivan

RESEARCH REPORT NO. 28

ucc
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

MIC
MARY IMMACULATE COLLEGE
COLÁISTE MHUIRE GAN SMÁL

A report commissioned by the NCSE.
All NCSE research reports undergo peer review.

2020

The National Council for Special Education has funded this research.
Responsibility for the research (including any errors or omissions) remains with the authors. The views and opinions contained in this report are those of the authors and do not necessarily reflect the views or opinions of the Council.

© NCSE 2020

National Council for Special Education
1-2 Mill Street
Trim
Co Meath

T: 046 948 6400

www.ncse.ie

Foreword

The NCSE is pleased to publish the evaluation of the first year of the In-School and Early Years Therapy Support Demonstration Project. This innovative project involved the development and implementation of a speech and language and occupational therapeutic support model for mainstream schools, special schools and early years' settings. It saw a unique collaboration between the Departments of Health, Education and Children along with the HSE and the NCSE to collectively deliver therapeutic supports and build capacity in 75 schools and 75 early years' settings under a new model of provision.

It was delivered by a team of 31 speech and language and occupational therapists, supported by clinical leads and therapy managers. In undertaking the evaluation, the researchers engaged with project staff and therapists, surveyed school principals, centre managers, teachers and early years' practitioners on the impact on the project. They also analysed goal data relating to the activities and targets set within each setting, and the extent to which they were achieved. They undertook further in-depth work in 20 schools and early years' settings where they spoke with students, parents and educators, and observed the model being implemented.

The evaluation found a number of positive impacts arising from the first year. Educators reported that they had an increased ability to differentiate instruction as a result of therapists being in the setting. They also reported that the strategies and information they acquired during their work with therapists enabled them to identify needs, created more positive interactions with students/children, and notably resulted in more positive academic engagement by students/children. Participating students spoke positively about their experiences of the project, while parents noted the potential of the project to overcome waiting lists for therapy in the community, and the in-school nature of provision negating the need for children to be taken out of school to a clinic-based setting.

The evaluation noted a number of challenges as well. There were significant delays in getting therapists in post and greater time than had been anticipated to ensure therapists were familiar with the requirements of an education environment. Therapists reported ongoing challenges arising from the management structure, including confusion over reporting lines and role clarity. Challenges were faced in the management and sharing of the large volume of data gathered across settings and different levels of the model.

The NCSE welcomes the Government commitment to continue to provide in-school therapy supports as part of the 2020/2021 School Inclusion Model (SIM) and to extend and expand the SIM to two other pilot areas in 2021. This evaluation identified important lessons for us to consider in this expansion so that the delivery model can be improved. Fundamentally, the evaluation demonstrates the potential that delivering in-school therapy supports has for improving outcomes for students.

Teresa Griffin
Chief Executive Officer

October 2020

Acknowledgements

The authors would like to thank the NCSE for commissioning this work. We would also like to extend our heartfelt thanks for the welcome and collegiality extended by the Demonstration Project Management Team and therapy staff over the course of the year. In addition, we extend our heartfelt thanks to the wonderful staff on-site in each educational setting visited, and to the children and families we had the pleasure of meeting.

Contents

Foreword i
Acknowledgments ii
Index of Tables viii
Index of Figures viii
Acronymns ix
Executive Summary 1

1. Introduction 8

1.1 Introduction 8
1.2 Structure of the Report 8

2. Project Background and Description 9

2.1 Introduction to Situate the Demonstration Project 9
2.2 Demonstration Project Development 10
2.3 Broader Context of Health and Education Provision in Ireland to Situate the Project 11
2.4 Models of Provision for In-School Therapy Support that Exist in Ireland 14
2.4.1 The Access and Inclusion Model (AIM) 14
2.4.2 Child Development Initiative (CDI) 16
2.4.3 National Educational Psychological Service (NEPS) 16
2.4.4 National Behaviour Support Service (NBSS) 17
2.4.5 Special Education Teaching Model (SET) 19
2.4.6 Demonstration Project: Frameworks for Support 19
2.5 Summary of Findings from Existing Models in Ireland 19
2.6 Demonstration Project Model: Aims and Objectives 20
2.6.1 Aims of Demonstration Project 21
2.6.2 Describing the Tiered Model of Therapy Service Provision 22
2.6.3 Roles of Schools and Project Therapists at Each Tier 26
2.6.4 Roles of the HSE in the Demonstration Project 28
2.7 Demonstration Project Working Group: Pre-Project Implementation 29
2.7.1 Posts to Support the Project 30
2.7.2 Recruitment and Employment Framework 31
2.7.3 Selection of Region 32
2.7.4 Selection of Schools for Inclusion 32
2.7.5 Allocation of Project Therapists to Educational Settings 33

2.8 Demonstration Project Initiation and Key Stages for Implementation 34
2.8.1 Project Action Plan 34
2.8.2 Project Procedures 35
2.8.3 Therapist Induction 35
2.8.4 School/ELC Engagement 35
2.8.5 Setting up Project Teams 36
2.9 Summary and Conclusion 36

3. Literature Review 38

3.1 Introduction 38
3.2 School-Based Therapy Practice in Tiered Models of Service Delivery 39
3.3 School-Based Tiered Models: International Evidence 41
3.4 Evidence Base for Implementing the Tiered Model of Therapy Service Delivery 43
3.4.1 Establishing Capacity in a School District – Experiences from the USA and Canada 44
3.4.2 Establishing a Project Team for Implementing the Model 44
3.4.3 Screening and Profiling the School: Needs Assessment 45
3.4.4 Monitoring Tiered Models of Intervention and Fidelity 45
3.5 Key Ingredients for Success in Implementing a Tiered Model of Therapy Provision 46
3.5.1 Relationship Building 46
3.5.2 Knowledge Translation 46
3.5.3 Enhancing Participation for Children and Youth 46
3.6 Key Challenges to Implementing a Tiered Model of Therapy Provision 47
3.7 The Tiered Model: Examining what Constitutes Each Tier 48
3.7.1 Tier 1 48
3.7.2 Tier 2 50
3.7.3 Tier 3 51
3.8 Outcomes and Effectiveness Relevant to Demonstration Project 53
3.9 Conclusion 55

4. Methodology 57

4.1 Introduction 57
4.2 A Multi-Method Ecological Evaluation Framework 57
4.3 Literature Review 59

4.4 Evaluation Methods 60
4.4.1 Documentary Analysis 62
4.4.2 Online Questionnaires 63
4.4.3 World Café 63
4.4.4 Semi-Structured Interviews 64
4.4.5 Drawing and Telling 64
4.5 Access and Sampling 64
4.6 Data Analysis 65
4.7 Trustworthiness 67
4.8 Limitations 68
4.9 Summary 69

5. Implementation Findings 70

5.1 Introduction 70
5.2 Recruitment and Employment Framework 72
5.2.1 Key Project Successes 72
5.2.2 Summary of Findings 72
5.3 Induction, Staff Training & CPD 73
5.3.1 Key Achievements 73
5.3.2 Findings 73
5.4 Day-to-Day Management & Data Governance 75
5.4.1 Key Achievements 75
5.4.2 Findings 76
5.5 School/ELC Engagement 77
5.5.1 Key Achievements 77
5.5.2 Findings 78
5.6 Implementation of Tiered Service Delivery 80
5.6.1 Findings 80
5.6.2 Tier 2 Implementation 86
5.6.3 Tier 3 Implementation 88
5.6.4 Overall Summary of Findings Tiers 1-3 90
5.6.5 Summary 93
5.7 Summary 94

6. Impact Findings 96

6.1 Evaluation of Impact 96
6.1.1 Context of the Demonstration Project 97
6.1.2 Impact Concerning Implementing a Tiered Therapy Model in an Irish Context 98
6.1.3 Impact Concerning Capacity Building Amongst Educators 98
6.1.4 Impact Concerning Children 101
6.1.5 Impact Concerning Professional Support, Training and Guidance for Parents 102
6.1.6 Impact Concerning Inter-Professional and Inter-Sectoral Working 102
6.2 Impact Evaluation: Perspectives of Demonstration Project from Case Study Settings 103
6.2.1 Impact and Outcomes as Experienced in Early Learning and Care Setting 104
6.2.2 Impact and Outcomes as Experienced in Primary Schools 108
6.2.3 Impact and Outcomes as Experienced in Post-Primary Schools 111
6.2.4 Impact and Outcomes as Experienced in Special Schools 116
6.3 Conclusion 119

7. Discussion 121

7.1 Contextualising the Demonstration Project 121
7.2 Project Successes 122
7.2.1 Demonstration Project Vision as an Evidence-Based Model of Therapy Provision 122
7.2.2 Demonstration Project Initiation and Implementation 122
7.2.3 An Emerging Model of Inter-Sectoral Engagement, Collaboration and Service Delivery 123
7.2.4 Evolving New Operating Practices: Management 123
7.2.5 Evolving New Operating Practices: Recruitment and Data Recording 123
7.2.6 Development of a Staff Induction Programme 124
7.2.7 School Engagement and Needs Assessment 124
7.2.8 Implementing the Tiered Model of Therapy Provision 125
7.2.9 Fidelity to Tiered Service Delivery 125
7.2.10 Outcomes for Knowledge Translation and Capacity Building 126

7.3 Challenges 126
7.3.1 Inter-Sectoral Service Provision: Management, Recruitment and Processes 126
7.3.2 Induction and Education Programme for School-Based Practice for Therapists 128
7.3.3 Project Initiation Phase: Engagement and Needs Assessment 129
7.3.4 Implementing the Tiered Model of Therapy Provision 130
7.3.5 Broader Considerations to Support Development and Future Practice 130
7.4 Conclusion 134

References **136**

Appendices **153**

Appendix A: Aims of Demonstration Project 154

Appendix B: P4C Outcomes 155

Appendix C: Evidence of Effectiveness for Each Tier, and Characteristics of the Tiered Model of School-Based Therapy Practice 156
Tier 1 Evidence and Outcomes 156
Tier 2 Evidence and Outcomes 157
Tier 3 Evidence and Outcomes 157

Appendix D: Service Frameworks 160

Appendix E: Overview of the Range of Documentation Examined 165

Appendix F: Online Questionnaire Example 166

Appendix G: World Café Processes 177

Appendix H: Sample Interview Transcripts 178

Appendix I: Sample Information Letters and Consent/Assent Forms 180

Appendix J: Project Plan for Demonstration Project 189

Index of Tables

Figure 2.1: Development of the Demonstration Project 11
Figure 2.2: Service Pathway in Disability Services 14
Figure 2.3: The Access and Inclusion Model 15
Figure 2.4: NEPS Continuum of Support Framework 17
Figure 2.5: NBSS Model of Support to Schools 18
Figure 2.6: Multi-Tiered Continuum of Support 21
Figure 2.7: Governance Structure for the Demonstration Project 29
Figure 2.8: Recruitment Model (Bespoke to the Demonstration Project) 31
Figure 2.9: Number of Settings (by Setting Type) Participating in the Demonstration Project 33
Figure 3.1: An Integrated Model of School-Based Therapy 56
Figure 4.1: Multi-Tiered Continuum of Support 58
Figure 4.2: Ecological Contexts for Collection of Data 59
Figure 4.3: Evaluation Methodology: Analysis Domains 60
Figure 4.4: Overview of Data Collection and Analysis 61
Figure 5.1: An Integrated Model of School-Based Therapy 70
Figure 6.1: Evaluation Process for the Demonstration Project 96
Figure 6.2: Educators' Overall Assessment of the Demonstration Project, from all Four Settings, in Respect of Particular Dimensions and the Extent to which these were Realised (n=83) 100
Figure 6.3: Key Components for Effective Therapy Provision in an ELC Context 105
Figure 6.4: Exemplar Interventions Implemented at Each Tier in ELC Settings 106
Figure 6.5: Developing Through Play in the ELC Context: ELCA_C1 *"Everything I Love about Pre-School"* 107
Figure 6.6: Key Components for Effective Therapy Provision in a Primary School Context 108
Figure 6.7: Exemplar Interventions Implemented at Each Tier in Primary School Settings 110
Figure 6.8: Key Components for Effective Therapy Provision in a Post-Primary School Context 112
Figure 6.9: Exemplar Interventions Implemented at Each Tier in Post-Primary Settings 113
Figure 6.10: Therapy Intervention Evidence in PPS_B 114
Figure 6.11: Key Components for Effective Therapy Provision in a Special School Context 116
Figure 6.12: Exemplar Interventions Implemented at Each Tier in Special School Settings 117
Figure 6.13: "My School" as Communicated by SSA_C1 119

Index of Figures

Figure 2.1: Development of the Demonstration Project 11
Figure 2.2: Service Pathway in Disability Services 14
Figure 2.3: The Access and Inclusion Model 15
Figure 2.4: NEPS Continuum of Support Framework 17
Figure 2.5: NBSS Model of Support to Schools 18
Figure 2.6: Multi-Tiered Continuum of Support 21
Figure 2.7: Governance Structure for the Demonstration Project 29
Figure 2.8: Recruitment Model (Bespoke to the Demonstration Project) 31
Figure 2.9: Number of Settings (by Setting Type) Participating in the Demonstration Project 33
Figure 3.1: An Integrated Model of School-Based Therapy 56
Figure 4.1: Multi-Tiered Continuum of Support 58
Figure 4.2: Ecological Contexts for Collection of Data 59
Figure 4.3: Evaluation Methodology: Analysis Domains 60
Figure 4.4: Overview of Data Collection and Analysis 61
Figure 5.1: An Integrated Model of School-Based Therapy 70
Figure 6.1: Evaluation Process for the Demonstration Project 96
Figure 6.2: Educators' Overall Assessment of the Demonstration Project, from all Four Settings, in Respect of Particular Dimensions and the Extent to which these were Realised (n=83) 100
Figure 6.3: Key Components for Effective Therapy Provision in an ELC Context 105
Figure 6.4: Exemplar Interventions Implemented at Each Tier in ELC Settings 106
Figure 6.5: Developing Through Play in the ELC Context: ELCA_C1 *"Everything I Love about Pre-School"* 107
Figure 6.6: Key Components for Effective Therapy Provision in a Primary School Context 108
Figure 6.7: Exemplar Interventions Implemented at Each Tier in Primary School Settings 110
Figure 6.8: Key Components for Effective Therapy Provision in a Post-Primary School Context 112
Figure 6.9: Exemplar Interventions Implemented at Each Tier in Post-Primary Settings 113
Figure 6.10: Therapy Intervention Evidence in PPS_B 114
Figure 6.11: Key Components for Effective Therapy Provision in a Special School Context 116
Figure 6.12: Exemplar Interventions Implemented at Each Tier in Special School Settings 117
Figure 6.13: "My School" as Communicated by SSA_C1 119

Acronyms

CPD	Continuing Professional Development
DCYA	Department of Children and Youth Affairs
DES	Department of Education and Skills
DoH	Department of Health
ELC	Early Learning and Care
ERC	Education Research Centre
GDPR	General Data Protection Regulation
HSE	Health Service Executive
MIC	Mary Immaculate College
NCCA	National Council for Curriculum and Assessment
NBSS	National Behaviour Support Service
NCSE	National Council for Special Education
NEPS	National Educational Psychological Service
OT	Occupational Therapy
P4C	Partnering for Change
PP	Post-Primary School
PS	Primary School
RfT	Request for Tender
RtI	Response to Intervention
SET	Special Education Teacher
SLT	Speech and Language Therapy

Executive Summary

Introduction

This report details the evaluation of the In-School and Early Years Therapy Support Demonstration Project (hereafter referred to as the Demonstration Project), which was implemented in the school year of 2018 to 2019, and which was concurrently evaluated by the authors of this report (the evaluation team). The evaluation team was led by three principal investigators and comprised a research group led by University College Cork (UCC) in collaboration with Mary Immaculate College (MIC), Limerick. The evaluation team represented the three core professions involved in the Demonstration Project, namely educators, Occupational Therapists and Speech and Language Therapists.

Background and Context for the Project

In 2016, *A Programme for a Partnership Government* acknowledged that providing earlier access to Speech and Language Therapy services could make a vital difference to children's future opportunities. In this context, the government articulated a commitment to introducing a new in-school Speech and Language Therapy service, designed to create stronger linkages between parents, teachers and Speech and Language Therapists. Funding was made available by the Department of Education and Skills (DES) to establish a Demonstration Project focused on the provision of an in-school Speech and Language Therapy service in the 2018/19 school year. The project was subsequently extended to include the provision of Occupational Therapy services and additional funding was provided by the Department of Children and Youth Affairs (DCYA) to include Early Learning and Care (ELC) settings in the Demonstration Project. This facilitated the inclusion of 150 sites in the project across ELC, primary, post-primary and special school settings. The Demonstration Project built upon experiences and expertise in delivering tiered model services to schools that has been pivotal to the approach adopted by the National Educational Psychological Services (NEPS), the National Behavioural Support Service (NBSS) and the Special Education Teaching Model. The Demonstration Project was embedded in the national drive from the DES, National Council for Special Education (NCSE), DCYA, the Health Service Executive (HSE) and the Department of Health (DoH) to promote and support the development of inclusive practice in education. The Demonstration Project therefore was founded on the principles of equity and the achievement of improved outcomes for all children through providing the right supports at the right time for all children.

Aims of the Demonstration Project

Established as an inter-agency partnership with the HSE, the Demonstration Project aimed to develop and test a tiered model for the delivery of therapy support across targeted ELC, primary, post-primary and special school settings in the HSE Community Healthcare Organisation, Region 7 (CHO 7 – Dublin West, Dublin South West, Dublin South City and Kildare/West Wicklow.

The Demonstration Project aimed to recruit a team of 31 Speech and Language Therapists and Occupational Therapists that would work alongside an inter-agency management team to:

- develop and evaluate a multi-tiered continuum of therapy service delivery focused on capacity building and providing inclusive experiences for children in 150 education settings
- explore effective models of collaborative partnership with education staff that would serve as a platform for the efficient delivery of services into schools and ELC settings
- explore models of effective inter-agency collaboration and efficient pathways of care for children and their families
- explore parameters of service access, and use and demonstrate optimal use of resources between therapists delivering services to schools and ELC settings and existing services available to children and families.

The tiered continuum of therapy support was structured within an internationally recognised and evidence-based model of tiered support. The model was articulated in frameworks that provide support for all children in a whole-school setting in Tier 1: targeted support for those at risk at Tier 2, and intensive, individual support for those with an identified need at Tier 3.

Evaluation of the Demonstration Project

The NCSE commissioned an independent evaluation of the Demonstration Project in order to test its effectiveness and assess the outcomes for the educational settings with regard to their capacity to support children and families. The evaluation also included a process element focused on assessing how the service design and delivery were operationalised.

The evaluation of the Demonstration Project was focused on measuring the impact *on* and *for* a broad range of project *stakeholders* and *beneficiaries*. Analysis of the effectiveness of the Demonstration Project was also conducted to examine the fidelity of the implementation of the tiered model of therapy service provision, and perspectives of policy and process stakeholders.

The design for this evaluation included the collection and analysis of quantitative and qualitative data from both documentary and participant sources. The evaluation comprised three phases of data collection and analysis from across the 150 sites, alongside targeted data collection in twenty sample sites which were identified for more in-depth analysis. In Phase 1, programme documentation was examined, and surveys and interviews of project staff and management were conducted to elicit the experiences of project initiation. In Phase 2, more detailed documentary analysis was conducted alongside targeted focus groups and interviews on-site with staff, students and leadership at the 20 sample participating schools and ELC settings to examine the ongoing processes of implementation. Finally, in Phase 3, outcomes and impact data were collected from project documentation for final review and analysis, consisting primarily of educational settings' charts and files, with emphasis on the 20 case study files, alongside a final analysis of the Target Tracker data.[1]

1 A summary overview of data sources is presented in Table 4.3 Section 4.

Data were collected through multiple methods. Surveys, questionnaires and telephone interviews were conducted with 87 school principals and ELC managers, 212 education staff, 26 parents and 15 members of the project's Working Group. Focus-group meetings and periodic face-to-face interviews were conducted with all members of the management team including the Project Lead, two HSE Managers and three Clinical Leads. A further 77 children, 83 school and ELC staff and 27 project therapists participated in face-to-face interviews and focus groups, many of which were conducted at the project sites. Twenty sites were identified as sample sites for more in-depth analysis. All 20 sites were also visited by the project team, and during these visits, focus-group interviews were conducted with 55 staff. Concurrently, 77 children/students participated in focus groups or interviews on-site. Telephone interviews were subsequently conducted with 26 parents of these children. To conclude the process, further surveys were conducted with the Project Management Team and therapists: 27 therapists, and 83 school- and ELC-based personnel, including teachers, school principals, managers and ELC practitioners who participated in the project, took part in a post-project survey questionnaire. This process also involved regular audit and analysis of a sample of documentation at four different time points across the year, pertaining to 57 of the participating sites, including in-depth review of, and site visits to, 20 sample settings.

Throughout the evaluation, research evidence from peer-reviewed publications was reviewed and analysed to identify core characteristics of a tiered model for school-based therapy practice, and as a benchmark for evaluation from a best-practice perspective.

Summary of Findings

The project was successful in its aim to implement an in-school continuum of therapy supports in 150 schools and ELCs, serving more than 27,678 children. A key part of the initial implementation was to conduct a needs assessment. An appraisal of the needs of participating ELCs and schools was conducted at 131 (87%) of the participating sites, which in many instances included environmental audits, accessibility reviews, surveys and examination of staff training needs. From this, objectives were set based on identified need, and this most frequently involved the need for further education related to the tiered model of therapy service. During the first year of the project, over 1,155 educators including teachers, SNAs, managers and principals received training through attendance at 75 separate education events. Furthermore, over 138 events were organised to engage parents and caregivers and over 174 children received individualised Occupational Therapy and Speech and Language services at their schools or ELCs.

In total, 1,736 Occupational Therapy and Speech and Language Therapy interventions were designed and implemented across participating ELC settings (897), Primary Schools, Post-Primary Schools, Special Schools (839 across all 3 setting types). Of these interventions, over 1,141 (67%) were seen through to successful completion with a further 595 interventions (34.3%) were reported as partially achieved by the close of the school year.

To support the above achievements the Demonstration Project quickly established a recruitment framework in partnership with the HSE that facilitated the rapid recruitment of skilled, experienced (averaging 9.3 years of relevant service) speech and language therapists and occupational therapists. This was coupled with a bespoke induction programme for new staff that drew from the accrued experiences of participating stakeholders and international best practice. The induction programme and accompanying collaborative practices served to provide a platform of skills and aptitudes for all 31 therapists to successfully begin building relationships with education settings, identify the therapeutic and inclusion needs at these settings and to begin designing and implementing tiered therapeutic interventions. Findings from the survey and interview data highlighted that 46% of therapists participating in the project expressed satisfaction with their induction programme, with therapists reporting that they felt equipped to successfully deliver a tiered model of therapy services to schools.

The Demonstration Project successfully established a data recording and management system that comprised detailed hard-copy written records (school files and charts for individual children), an electronic system for recording tiered-intervention targets, and secure storage and retrieval systems for these.

Of particular note was that efforts by the Demonstration Project to build relationships, establish collaborative practices, share knowledge and build capacity were particularly welcome. The initial engagement model employed at the 150 sites provided a platform for establishing operational project teams at a majority of participating education establishments. These project teams comprised an Occupational Therapist and Speech and Language Therapist from the Demonstration Project staff, and education and support staff at each participating setting. Project teams established a programme of collaborative capacity-building in preparation for conducting in-depth analysis of the inclusion needs of the school or ELC environment, and identification of interventions and strategies that supported children's participation. Examination of project documentation, including school files, demonstrated a high level of direct and indirect contacts between project therapists and staff at participating settings. These included email and telephone contact, visits, on-site meetings, drop-in events and the direct inter-disciplinary delivery of tiered-model interventions. The project saw a high degree of engagement with schools throughout the year, with therapists visiting each location on average twelve times during the first six months, with this frequency increasing in the course of the school year. Project therapists also demonstrated innovative ways of increasing the impact of their school visits, organising engagement events for teachers, education staff and parents such as drop-in clinics and collaborative planning meetings.

Of the total number of therapy interventions, 1,248 (71%) were focused on providing *universal therapy supports* that would facilitate school participation for *all children* (Tier 1 interventions). These included 169 staff training and continued professional development interventions, and 123 whole-class inclusion initiatives. Over 13% (229) of the therapy initiatives implemented in schools and ELCs focused on establishing inclusion strategies for whole classes and supporting groups of children specifically identified as at risk (Tier 2 interventions). These interventions included targeted initiatives focused areas of specific need such as language development, sensory regulation, handwriting and supporting motor development. Project teams delivered 143 programmes focused on engaging and supporting *parents* and other caregivers. Therapists also delivered over 280 (16% of all interventions) individual supports and one-to-

one interventions to children identified across all of the 150 participating settings (Tier 3 interventions). This included 167 one-to-one therapy interventions for individual children within their schools or ELCs.

Evaluation of tiered interventions delivered to schools and ELCs reported an increase in staff confidence and ability in the early identification of children with education or inclusion needs, increased skills in modifying classroom environments and teaching approaches to accommodate all learners and an understanding the role of therapists in supporting all children in education. Data gathered during the final phases of the project indicated that educators and participating staff were satisfied with: (i) resource sharing (90%), (ii) inter-professional communication (87%), (iii) collaborative decision-making practices (83%), (iv) mutual, professional respect (81%) and (v) shared problem-solving (81%).

Survey data from educators and staff at participating settings highlighted the positive impact of the project in some key indicators for successful school inclusion, namely: (i) increased academic engagement (80%), (ii) increased positive classroom interactions (70%), (iii) increases in positive social interactions for children (69%) and (iv) increased differentiated instruction (68%). Interview data indicated that the availability of therapy service provision in school served to aid identifying and supporting children who had previously been considered 'hard to reach'.

The Demonstration Project faced a number of external challenges in preparations and during the year. The short period available to set up the project limited time available to allow the management team to thoroughly profile and build an accurate picture of the therapy needs at participant settings. The project was also reliant on the adoption of recruitment, data management and clinical supervision practices from partner agencies, most notably the HSE. While the recruitment arrangements put in place for the project facilitated the rapid employment and management of experienced therapy staff, it did not provide a flexibility in recruitment required to support quickly backfilling vacant posts and/or identifying therapists that have a specific range of skills or experience matched with the tiered model of therapy service delivery proposed in the Demonstration Project. Interviews with project therapists indicated that the inter-agency management model caused some levels of confusion regarding management, supervisory and professional/clinical support arrangements for individual therapists. Similarly, the novel nature of the therapy services proposed, along with the multi-agency nature of the key project participants, contributed to issues with duplication in recording information, access to particular project data and the need to adhere to data management standards such as general data protection regulation (GDPR).

Although successful in delivering comprehensive and peer-led induction opportunities that ensured rapid knowledge and skills development for therapy staff at the outset of the project, interview data from the project team identified that the induction programme system was not sustainable and did not provide an equitable platform for knowledge and skill development for staff recruited later over the project lifetime. Furthermore, the project therapist team identified the need for advanced and ongoing CPD for developing new knowledge in capacity-building, knowledge translation and collaborative consultation, which are core skills required for this new way of therapy provision.

Survey and interview findings highlighted an initial lack of awareness and understanding of the nature of tiered service delivery amongst participating education staff. As such, much of the early project efforts were dedicated to addressing this through provision of bespoke information resources, presentations by the Project Management Team and the delivery of in-school training across all participant settings. Furthermore, the model of service delivery was deployed on a phased basis, which resulted in a delay to the implementation of Tier 2 and Tier 3 interventions until after January 2019. The evolving nature of the service model was such that a fully operational multi-tier continuum of therapy support was not in place until late in the project, limiting the time available to evaluate it in its entirety and to benchmark its successes against international practice examples. However, evidence points to a definite maturation of the model over the course of the project implementation with an increase from 13 to 28 distinct categories of interventions provided and recorded by project staff.

Of the participating education settings, surveys revealed that approximately 10% of their student numbers were identified as having education and/or inclusion needs such that they warranted therapy services. Of the participating settings, the majority (91%) did not have and could not access Speech and Language Therapy or Occupational Therapy services without the Demonstration Project. This evaluation revealed that educators and staff at participating schools and ELCs responded positively to the introduction of in-school, tiered therapy services. Further survey data revealed that approximately 93% of educators and participating staff surveyed would recommend the continuation or expansion of in-school therapy services as proposed in this project. Interview data indicated that the availability of therapy service provision in school served to aid identifying and supporting children who had previously been considered 'hard to reach'.

Conclusion

This report aims to provide a comprehensive overview of the rationale for, and commencement and implementation of, the In-School and Early Years Therapy Support Demonstration Project, which was established and conducted in 2018-2019. Building on inter-sectoral expertise and informed by best evidence in school-based practice, the Demonstration Project signals a paradigm shift in therapy provision in educational settings in Ireland. It demonstrates innovation in establishing a tiered model of therapy services delivery that reflects the unique context of education in Ireland and is considerate of challenges associated with multi-agency funding, employment practices, referral systems and care pathways currently in existence. This required that the project team develop new working practices for therapy service delivery (the tiered model), while at the same time implementing and managing a project ambitious in its aims and scope.

Nonetheless, the project achieved significant successes in establishing and nurturing the relationships required with schools and ELCs to effectively deliver services. Furthermore, endeavours to build capacity through the provision of training and continuous professional development resulted in an increased understanding amongst participants as to the nature of tiered therapy service provision to schools. Through the establishment of collaborative project teams, comprising project therapists and education staff at participant settings, the service needs across participating settings were identified and successfully addressed through multiple, tiered Speech and Language and Occupational Therapy interventions.

The phased introduction of tiered interventions across the school year established an understanding of the nature of tiered service delivery on a systematic basis with a full-service offering firmly established across the majority of participating settings by the end of the school year. It is anticipated that the model of service provision as it evolves should be guided by best practice from elsewhere, while continuing to evolve in its entirety to reflect the particular requirements necessary to support participation and inclusion firmly in an Irish context. As the implementation of the project extends, the continued delivery of an integrated, tiered model of therapy provision in schools will allow a more detailed examination of the impact of such a model on inclusion in education. Furthermore, continued efforts to deliver the model in its entirety will allow the fidelity of the model in an Irish context, and support benchmarking its success against international examples of good practice.

Future success however, will require further effort to ensure that challenges pertaining to recruitment, induction, management, clinical supervision and data recording and access are resolved. The establishment of a governance model alongside the relevant processes that underpin successful service delivery in education and early learning will best serve the long-term success of in-school therapy service provision. Similarly, as experience of delivering tiered therapy services in schools increases, continued efforts should ensure that service delivery retains a distinct identity, directly addressing participation and inclusion in education. As Tier 2 and Tier 3 interventions in particular increase in prominence, those charged with providing the service must remain cognisant that services do not risk replicating or duplicating existing clinic-based provision.

From this evaluation, it is clear that the delivery of services in an efficient manner across health and education sectors is complex and requires bespoke solutions for some of the challenges that emerge. According to the World Health Organisation (2011), the inclusion of children with disabilities into educational settings is the responsibility of the educational system in each state, as it is that system that is best able to determine the special educational needs of each student. Evidence from international research highlights that school-based practice is oriented on a strengths-based model of support, with less emphasis on diagnosis and more on addressing educational need through whole-school, contextual responses. Overall, the necessity of having a clear organisational framework for service delivery that maximises the capacity to deliver this inclusive, strengths-based philosophy has been identified as an essential feature. According to the evidence, and as acknowledged by the World Health Organisation, the educational sector is best placed to take responsibility for leading and delivering a cohesive inclusion programme that includes school-based therapy services.

This team, charged with evaluating its first year in existence, welcomes the decision to extend the project by a further year and anticipates not only further success but anticipates greater development in establishing an evidence-based, sustainable model of delivering Speech and Language Therapy and Occupational Therapy directly to the education sector in Ireland.

1. Introduction

1.1 Introduction

The purpose of this document is to present the findings from the University College Cork/Mary Immaculate College research team evaluation of the current In-School Demonstration Project as commissioned by the National Council for Special Education (NCSE). The Demonstration Project was established to develop and test a new model for the delivery of in-school and pre-school therapy service provision in the Health Services Executive (HSE) Community Healthcare Organisations (CHO) Region 7 (Dublin West, Dublin South West, Dublin South City and Kildare/West Wicklow), across a range of school and pre-school settings, in conjunction with the HSE. The support provided by the project is intended to supplement and not replace existing and/or planned additional HSE therapy services.

The purpose of the Demonstration Project was to focus on developing more significant linkages between educational and therapy supports. The aim was to provide for in-school and pre-school therapy services within a tiered model, which encompasses professional support, training and guidance for school/pre-school staff and parents, amongst other things.

The aim of the evaluation project was to measure the impact of this Demonstration Project in the participating 150 schools and Early Learning Centre (ELC) settings.[2] This report presents a background to the study, a synopsis of relevant literature analysed, a short description of the methodology employed, an outline of the evaluation findings and a discussion of the implications from this.

1.2 Structure of the Report

This report is structured into eight sections:

- Section 2 provides background and description of the Demonstration Project.
- Section 3 presents a synopsis of relevant literature for the tiered model of service delivery.
- Section 4 outlines the research design and objectives for the evaluation project.
- Section 5 describes general findings regarding project implementation and the evaluation of fidelity to the tiered model, highlighting key successes and challenges during the 2018/2019 school year.
- Section 6 outlines key impact findings highlighting significant achievements and challenges during the 2018/2019 school year.
- Section 7 provides an overall summary and discussion of the contents of the report.

2 The 75 schools and 75 Early Learning and Care centres (ELC) are located in HSE Community Healthcare Organisation (CHO) region 7.

2. Project Background and Description

2.1 Introduction to Situate the Demonstration Project

Achieving effective inclusive education systems is complex and is dependent on government commitment, adequate resourcing, inter-governmental collaboration, a responsive teacher education continuum, ongoing stakeholder consultation, an understanding of the complexity of inclusion, and consistent internal and external evaluation processes (Ring and O'Sullivan, 2019). There has been significant progress in achieving the inclusion of children with additional needs from Early Learning Centres (ELC) to post-primary level in Ireland in the past decade (Ring, Daly and Wall, 2018). The National Council for Special Education (NCSE) has played a central role in this process. Citing Winter and O'Raw (2010), the NCSE (2011) describes inclusion as:

- a process of addressing and responding to the diversity of needs of learners through enabling participation in learning, cultures and communities
- removing barriers within and from education through the accommodation and provision of appropriate structures and arrangements to enable each learner to achieve the maximum benefit from his/her attendance at school.

More recently, the NCSE approach to inclusion has involved recommending the development of an improved model of support for students (see Table 2.1).

Table 2.1: Key Changes

- Access to the right in-school support at the right time, delivered by the right people
- A broader range of support options, under a tiered model of support
- Care supports front-loaded
- Assessed need rather than disability diagnosis
- Continuity of access to better trained and qualified in-school personnel (NCSE, 2017, p.2).

The NCSE approach to inclusion provides the foundation for the Demonstration Project and serves to frame the implementation alongside a shared understanding of educational outcomes for students (NCSE, 2014):

- academic achievement-related outcomes (such as literacy, numeracy, examination results)
- attendance-related outcomes (such as school attendance, early school leaving)
- happiness-related outcomes (such as well-being, confidence, positive relationships, quality of life (QoL))
- independence-related outcomes: (such as resilience, socialisation, mobility, assistive devices)
- end of school outcomes.

Building on models already established by NEPS, NBSS, and SET[3], the Demonstration Project emerged as an innovative plan to develop a programme of therapy service delivery, which integrated therapy and education school-based provision to provide the right support at the right time in context. This section presents an overview of the new model of therapy intervention, beginning with the description of the project, followed by the purpose, aims and objectives, and including the project plans and vision for implementation.

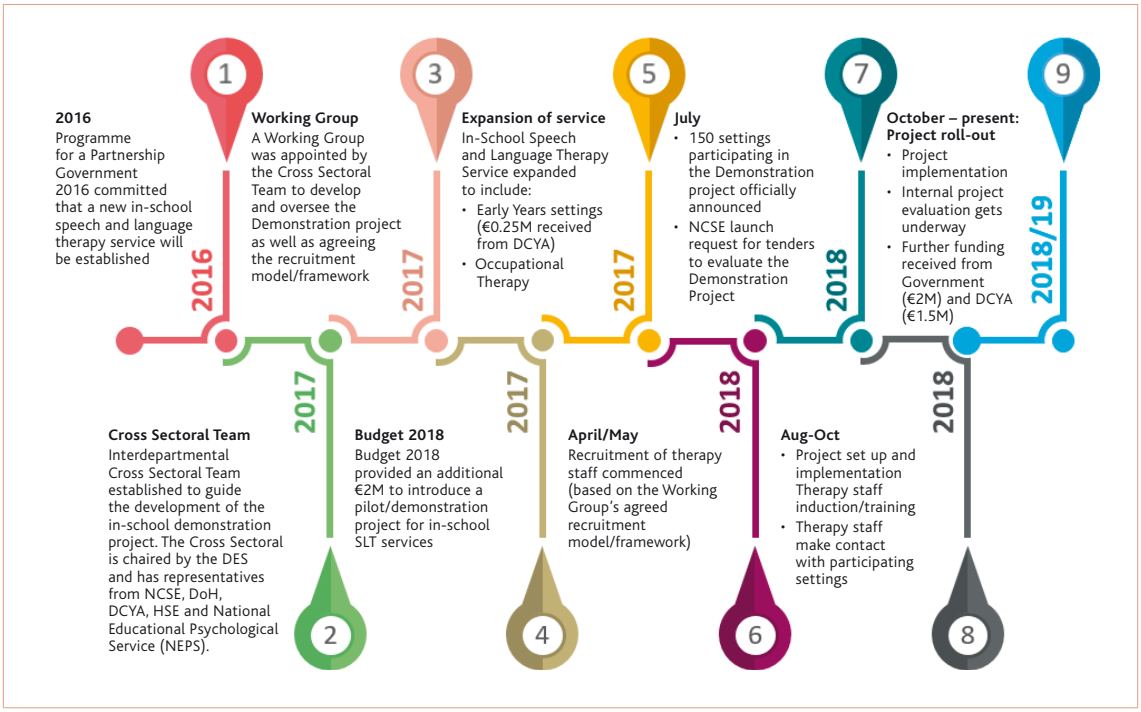
2.2 Demonstration Project Development

In 2016, the Programme for Partnership Government (Government of Ireland, 2016) committed to the establishment of a new model of in-school Speech and Language Therapy service. At the same time, the Department of Education and Skills (DES) strategy *Action Plan for Education 2016-19* (DES, 2016) was developed to provide strategic direction for improvements in educational impact for all children, including those with special needs. In this first document, and in the subsequent Action Plan for 2018, specific objectives were established. These included (i) developing an enhanced inclusion support service, (ii) developing more professional support for teachers and (iii) overall, to 'target policies and supports for learners with special education needs to support their participation and progression across the continuum of education' (NCSE, 2018, p. 32). In particular, the DES plan included a comprehensive review of the Special Needs Assistants (SNA) scheme, alongside an effort to introduce a new in-school Speech and Language Therapy service (Action 52) in 75 schools. This resulted in the establishment of an Inter-departmental Cross-Sectoral Team in 2017. Consisting of members from DES, NCSE, Department of Health (DoH), Department of Children and Youth Affairs (DCYA), Health Services Executive (HSE) and National Educational Psychological Service (NEPS), the role of the Inter-departmental Cross-Sectoral team was to establish the In-School Demonstration Project. In the last quarter of 2017, this team appointed a Working Group to develop the Demonstration Project, with established terms of reference. These terms of reference included Occupational Therapy services in addition to Speech and Language Therapy services.

The working group was required to develop a set of proposals by 24 November 2017. During intensive review of the implementation and outcomes of the SNA scheme 2016-2018, recommendations emerged that highlighted the need to introduce school-based therapy services (NCSE, 2017; NCSE, 2018). Budget 2018 provided €2M to launch a pilot/Demonstration Project for in-school Speech and Language Therapy services in 2018 (Demonstration Project Working Group, 2017). At this stage, the project was expanded to include the ELC sector, with an additional €0.25M funding made available from the DCYA (Demonstration Project Working Group, 2018). Total funding for the project at this stage was, therefore, €2.25M. On 6 July 2018, the Minister for Education and Skills, Mr Richard Bruton T.D., the Minister for Children and Youth Affairs, Dr Katherine Zappone T.D., and Minister for Health, Simon Harris T.D., announced that 75 schools and 75 ELC settings would be taking part in the project, located in Community Healthcare Organisation (CHO) 7. CHO 7 covers a geographical area comprising Dublin West, Dublin South West, Dublin South City and Kildare/West Wicklow. Figure 2.1 below offers a visual representation of key timeframes in the development of the Demonstration Project.

3 Which are described in section 2.4.

Figure 2.1: Development of the Demonstration Project



2.3 Broader Context of Health and Education Provision in Ireland to Situate the Project

Before presenting an overview of the Demonstration Project itself, it is essential to situate it in the context of current health and education provision and practices that have emerged in Ireland in the past fifty years. Traditionally in Ireland, Speech and Language Therapists and Occupational Therapists have a long history of working with children with special needs. However, they have not typically been employed directly to work in mainstream educational settings such as pre-schools and schools, and have different work practices compared to the rest of the educational sector. There are some exceptions. For example, Occupational Therapy and Speech and Language Therapy provision in special schools has been part of Irish paediatric therapy practice since the early 1980s (if not before), primarily in Non-Governmental Organisations (NGOs) such as St Michael's House and Enable Ireland services (Buchorn and Lynch, 2010). Another example is the presence of Speech and Language Therapists in primary schools to work in specific speech and language disorder (SSLD) classes for children. These are small group classes where children with developmental or specific speech and language disorders receive intensive Speech and Language Therapy, and Speech and Language Therapists work in close collaboration with the class teacher. In this example, the service is ring-fenced through a special arrangement with the DES to allow Speech and Language Therapists to work in the schools. The first of these classes was established in 1982, and the aim is to address the needs of those with speech and language disorder 'through appropriate education and intensive Speech and Language Therapy within the context of the broad and balanced primary school curriculum' (DES, 2005 p.5; see also Frizelle et al., in press).

Since the early 2000s, therapy provision in children's healthcare expanded into the nationwide network of community and primary care services. Thus, therapy service provision was introduced into local communities where before such services had been located primarily in NGOs.

The development of these services in primary and community care saw school-based therapy practice diminish. Therapy services have increasingly been standardised to a clinic-based model, rather than direct services to schools, as part of a rationalising effort to share resources equally across all community settings (Lynch, 2003; see also Dept. Health and Children, 2001).

Drawing on the traditions of medical-model approaches in healthcare, there is an emphasis from the outset on the child's difficulties or deficits. Typically, in clinic-based health services, work centres on the identification of specific deficits or diagnoses. The need for diagnostic assessment is a key driver for delivering this form of service, as this is the basis by which further supports from education or health can be accessed (e.g. assistive technology or accommodations for examinations).

In such service delivery models, once referred, children are typically added to a wait-list and seen in one-to-one assessment sessions (often aimed at detailed diagnostic evaluations) with limited time for an intervention. Such waiting lists often attract criticism from parents, therapists and other related stakeholders highlighting the numbers of individual children on such lists, the length of time required to see children and the fact that they do not accurately represent the needs within a community. To illustrate the inefficiencies within such service delivery models, statistics from the National Disability Authority in September 2019 indicate that within the HSEs primary care services there was a total of 10,507 children waiting for assessment and a further 7,323 children on waiting lists for treatment or intervention. For Occupational Therapy services in primary care, the picture is somewhat more bleak, with a total of 18,838 children on waiting lists for assessment with 8,109 of these waiting in excess of one year.[4]

Once a diagnosis has been determined, and following a waiting period, families are often offered a six-week block of intervention as a standard approach to a provision that aims to allocate limited resources fairly. The intervention takes the form of what is known as a remedial approach, whereby the therapist works to remediate the child's presenting difficulties. This approach as McCartney (1999) outlines the challenges encountered by children because of processes located within the child rather than within their learning environment. Although intervention can take the form of a team approach amongst the clinic therapy team (Carroll, Murphy and Sismith, 2013) this kind of service model does not commonly include educators or classroom staff as part of the team, nor does it necessarily support the generalisation of skills to the classroom and other appropriate settings. Intervention is often planned and delivered on an individual basis, followed by re-assessment to measure progress. Intervention success is often measured in terms of how many children have been seen and the impact on the wait-list, rather than on whether the intervention was effective in achieving outcomes for the child. As such, there is a need to explore new ways of working that target a strengths-based, capacity building approach instead, in the context of establishing strong therapist-education partnerships (Anaby et al., 2019).

4 Primary Care Therapy Statistics (September 2019) Communicated to the NCSE by the National Disability Authority (NDA).

The international consensus is that current clinic-based medical models are too costly and time-consuming. Consequently, new models of service delivery are emerging in communities and in schools nationally and internationally,[5] in the form of tiered approaches to provide a continuum of support.

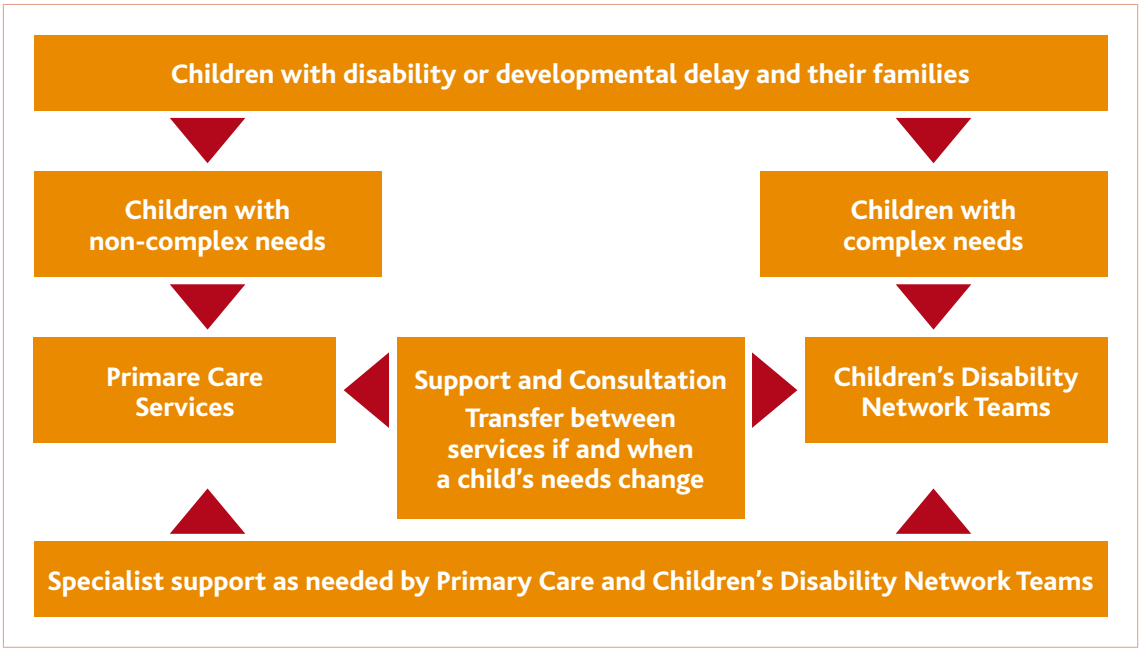
In 2009, the Report of the National Reference Group on Multi-disciplinary Disability Services for Children aged 5-18, amongst a raft of recommendations, emphasised the need for close working between the health and education sector. In this report, the Reference Group highlighted the need for moving from a clinic-based model of therapy service delivery towards school-based intervention for children (National Reference Group on Multidisciplinary Disability Services for Children aged 5 to 18 years, 2009).

The subsequent HSE programme, Progressing Disability Services for Children and Young People (Progressing Disabiltiies Services for Children and Yougn People, 2016), sought to develop a national, unified approach to the delivery of disability health services to ensure that health and education sectors would work together to achieve equitable, accessible services for all children and their families. This national process was based on a recognition that services should be based on need rather than diagnosis and should be delivered where children live. This is almost completed, and it is anticipated that full implementation is now possible.[6] Meanwhile, the link with the educational sector within this model is yet to be fully determined, and it is unknown to what extent services have been delivered in school contexts as envisioned.

5 International evidence of tiered models will be outlined briefly in chapter three.

6 https://www.oireachtas.ie/en/debates/debate/dail/2019-11-14/32/.

Figure 2.2: Service Pathway in Disability Services



Source: Progressing disabilities, 2016, p.10

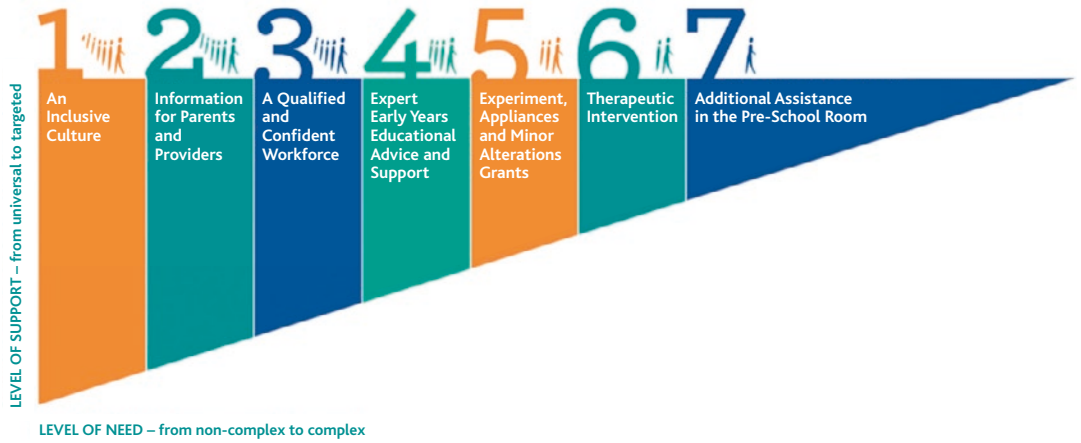
2.4 Models of Provision for In-School Therapy Support that Exist in Ireland

There are some examples of new models of service provision that are based on a continuum-of-support approach and include a specific focus on educator partnerships. Four Irish initiatives using a tiered-model approach are described in the next sections: two that relate to early years and two relating to schools.

2.4.1 The Access and Inclusion Model (AIM)

The cross-government Access and Inclusion Model (AIM) (see figure 2.3) was developed for Early Years following extensive consultation with a wide range of stakeholders, including the parents of children with additional needs (Inter-Departmental Group, 2015).

Figure 2.3: The Access and Inclusion Model



Focused on children availing of the Early Childhood Care and Education (ECCE) scheme and per best practice, the seven-level model adopts a child-centred approach by focusing on identifying and responding to each child's developmental level, abilities and needs, rather than relying exclusively on formal diagnoses. The seven levels of support range from universal (Levels 1-3) to targeted supports (Levels 4-7) based on the needs of the individual child. While each level is presented in the model separately, they are inextricably linked, and this deliberate linkage emerges as a key strength of the model. Level 1 is considered the foundation for the model and advises that a strong culture of inclusion be fostered and embedded to optimise each child's learning and development. The effectiveness of Level 1 is closely related to the provision of information for parents and providers at Level 2 and the necessity of developing a qualified and competent workforce that can confidently meet the needs of all children at Level 3. Levels 4 to 7 of AIM[7] are concerned with the provision of targeted support.

Following a year of AIM supports, an independent review (RSM, 2019) found that the AIM model is effective due to its provision of interventions that are child-centred and non-diagnosis-led. The levels of support available through AIM provide graduated support to address identified needs, offer support for a wide range of additional needs and ensure that supports are tailored to each individual's specific requirements, rather than a 'one size fits all' approach. However, within the AIM model, therapy support is included primarily as a Level 6 concern, for children who need access to therapy critically for supporting inclusion. Therefore, therapists are not viewed as co-participants in supporting the AIM model from a continuum of provision perspective across the seven levels.

7 See http://aim.gov.ie/better-start/.

2.4.2 Child Development Initiative (CDI)

The CDI was established in Tallaght to provide prevention and intervention programmes that support young children and families. From an initial assessment, community needs were identified, and a programme of provision designed to meet these needs based on best practice (Axford et al., 2004).

From this, a Speech and Language Therapy service was established as part of a series of programmes implemented by CDI to provide prevention and promotion programmes (the Chit Chat programme) for families in communication and language for disadvantaged children (Hayes, Keegan and Goulding, 2012). While the Speech and Language Therapy service was not described as a tiered model of delivery, it reflects a tiered model from a community healthcare perspective, moving across tiers of health promotion, to prevention to provision (see for example Bazyk and Arbesman, 2013), it also continued to work from a referral model of service provision, and received referrals for any child presenting with delayed development. In contrast to the traditional HSE services, however, this CDI speech therapy service was different, in that it focused more on prevention and early intervention in a socially disadvantaged area, and not specifically on disability (which is named a social care model rather than a healthcare clinical model). It aimed to promote children's speech and language development and provide intervention, where necessary through direct or indirect therapy in context. It also aimed to provide training to staff and parents and to promote Speech and Language Therapy within programme settings (Hayes, Keegan and Goulding, 2012). The Service was piloted from 2008-2011 and provided therapeutic support to 192 children who were otherwise unlikely to have been identified, referred or supported through any other existing service in Tallaght West.[8] An independent evaluation (Hayes, Keegan and Goulding, 2012; Hayes and Irwin, 2016) noted that findings were positive and outcomes from this social care model included: earlier referral and identification of needs, children being seen at a younger age than in clinic-based services, more responsive services and better community awareness of need, alongside a positive impact on the waiting times for other community Speech and Language Therapy services (Hayes, Keegan and Goulding, 2012).

2.4.3 National Educational Psychological Service (NEPS)

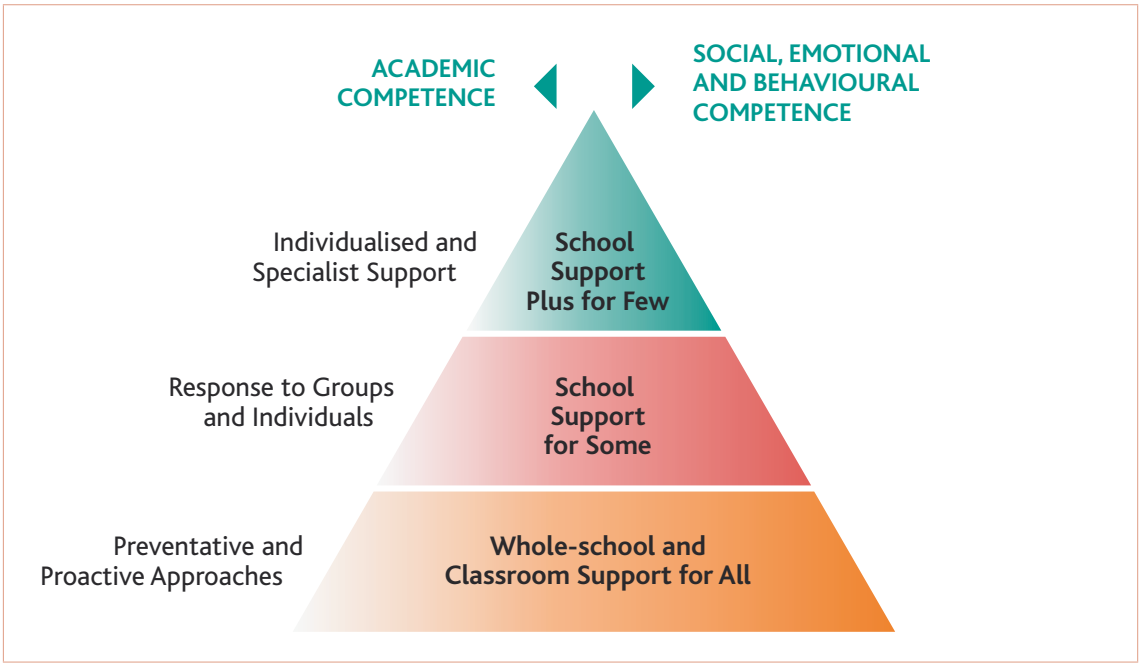
NEPS services were initially established by the DES to support the personal, social and educational development of all children through the application of psychological theory and practice in education (Citizens Information, n.d.). From the outset, NEPS psychologists worked in partnership with teachers, parents and children in identifying educational needs and offer a range of services aimed at meeting these needs (NEPS, n.d.).

However, more recently, in common with many other psychological services and best international practice (Grogg, Meyers and Meyers, 2017), NEPS adopted a consultative model of service delivery based on a tiered model (NEPS, 2007, see Figure 2.4). The focus of this tiered model is on empowering teachers to intervene effectively with pupils whose needs range from mild to severe, and transient to enduring (NEPS, n.d.). Specifically, the NEPS service in Ireland is designed to support students with learning, emotional or behavioural difficulties.

8 https://www.cdi.ie/our-programmes/chit-chat/.

The NEPS model of service is underpinned by evidence-based frameworks such as Response to Intervention (RtI) (Jimerson, Burns and Van Der Hayden, 2015) and European Best Practice Guidelines for Assessment (Pameijer, 2006). Also, several discrete aspects of the NEPS model of service have been evaluated in areas such as literacy (Nugent, 2010; Nugent and Devanney, 2010), mental health (Ruttledge, et al., 2016) and school consultation (Nugent at al., 2014). It is important to note, however, that there are no published evaluations of the NEPS Tiered Model of Service in terms of overall service impact. Although this model of provision does not include therapists to date, it is an example of an existing tiered model that has been embedded in schools in Ireland now for some time.

Figure 2.4: NEPS Continuum of Support Framework



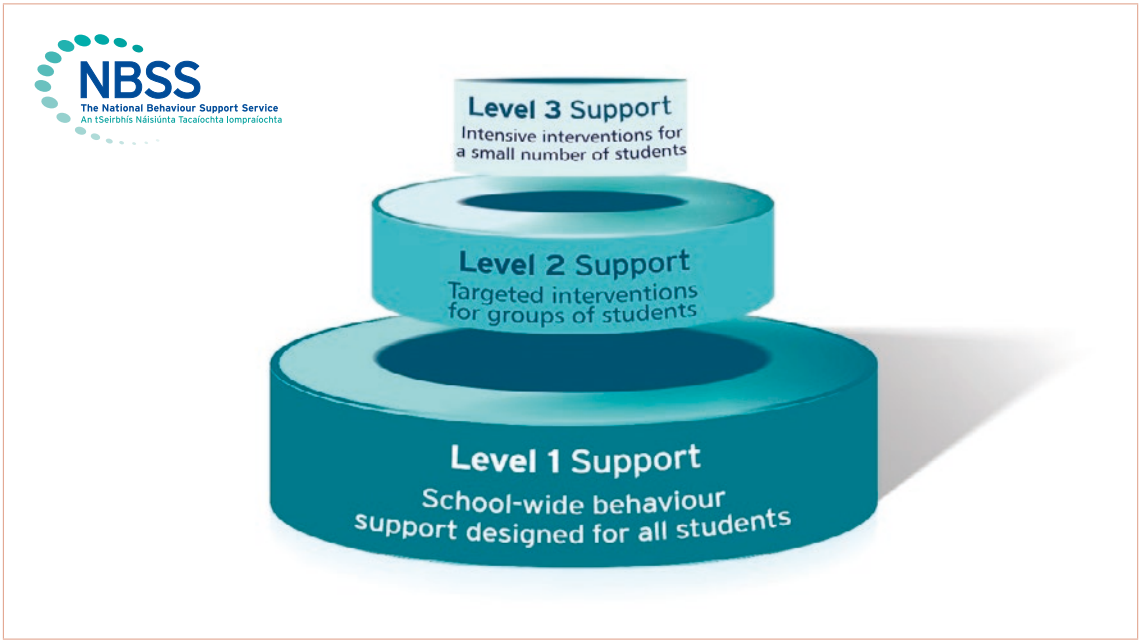
2.4.4 National Behaviour Support Service (NBSS)

The NBSS was established by the DES in 2006 to address the behavioural needs of students (relating to their social, emotional and academic needs) effectively, with interventions at different levels of intensity and support. The NBSS was a unique service at the time as it included an inter-disciplinary team encompassing Occupational Therapists and Speech and Language Therapists as well as educators, all employed by the education sector. Since then, the NBSS was subsumed under the NCSE. The NBSS adopts a tiered in-school model for the delivery of behaviour supports to schools (see Figure 2.5). The three levels described in the NBSS model are consistent with tiered models internationally that focus on a whole-school support at level 1, targeted intervention at level 2 and intensive, individual intervention at level 3. The model is explicitly based on tiered models of positive behavioural support.[9]

9 See www.ncse.ie for more information on the former NBSS.

Several studies have been conducted to document the impact and outcome of the NBSS programmes. In an evaluation of behaviour support classrooms (BSCs) for example, findings indicated that BSCs had been successful to varying degrees in bringing about an alteration in student behaviour and schools' views of changes in behaviour (Henefer, 2011). In another review of level 3 interventions, principal, teacher and student views of the NBSS intervention (intensive, individualised) were collected, mainly through surveys, and published in 2014. Findings from these surveys indicate positive attitudes towards the in-school interventions delivered (NBSS, 2014a; 2014b; 2014c). Further studies of Occupational Therapy and Speech and Language Therapy interventions were also conducted. A small-scale study examined two trial implementations of a group programme focused on self-regulation across a sample of 85 students in four post-primary schools. Reported student outcomes were positive (MacCobb, Fitzgerald and Lanigan-O'Keeffe, 2014). A randomised controlled study involving over 300 post-primary students in Irish schools examined the effectiveness of a whole-class vocabulary intervention delivered by English teachers with support and training from Speech and Language Therapists. Results indicated that students who received the intervention improved significantly more than those who did not on two measures (Murphy et al., 2017). Similar to the NEPS services, the NBSS is a service that described itself as focusing on the behavioural needs of students for learning.

Figure 2.5: NBSS Model of Support to Schools



2.4.5 Special Education Teaching (SET) Model

Following the publication of the report *Delivery for Pupils with Special Educational Needs* by the National Council for Special Education (NCSE 2014), a revised model for the use, organisation and deployment of additional teaching resources was developed introduced by the DES in September 2017 (Department of Education and Skills 2017a, 2017b). The NCSE identified some limitations that required addressing to ensure that all schools had access to a sustainable, balanced and equitable model for providing additional teaching supports for students. Building on existing good practice in schools, the revised research-based model is based on the principle that appropriate provision for students with special educational needs is located within an inclusive whole-school framework. Key components of an inclusive whole-school framework are identified as: good practice in the identification of students' needs; effective teaching and learning for all students; positive collaborative relationships and engagement between schools, parents/guardians and pupils; and a focus on prevention and early intervention and attention to monitoring recording and assessing students' outcomes and achievements. The model is aligned with the Continuum of Support framework in acknowledging that special educational needs are associated with a continuum ranging from mild to severe, and may be transient or long-term, which necessitates different levels of support based on students' individual needs (Department of Education and Science, 2007). In the school context, therefore, support is provided at a classroom, school support level and school support plus level. A vital principle of the model highlights the critical importance of students with the most significant level of need having access to the highest level of support.

2.4.6 Demonstration Project: Frameworks for Support

Much of the knowledge and expertise reported above was leveraged in preparation for the Demonstration Project. Preparations from deploying a model of therapy services to schools and ELCs built upon previous work by NCSE and other stakeholders in some of the published work and initiatives that are documented here. Initially, a Framework of Support was developed that would inform both the project team and other stakeholders as to what a tiered model of therapy service delivery would constitute and what could be expected in the context of addressing the capacity building needs for school staff, the classroom-based support and the interventions required by students with specific educational needs. This and a further framework modifying the service model to reflect the needs of ELCs were developed collaboratively by staff from the NCSE, drawing upon their collective expertise alongside colleagues from the University of Limerick and Trinity College, Dublin. These framework documents are included in Appendix D of this report and are elaborated upon further in sections 2.6.2 and 2.6.3 of this report.

2.5 Summary of Findings from Existing Models in Ireland

Although examples of tiered models of practice exist, they are not prevalent, and educators continue to report unmet needs in supporting inclusion. For instance, in seeking to provide a continuum of support within an inclusive school culture, the absence of adequate multi-disciplinary support for teachers has emerged as a potential barrier. Recent research suggests that resourcing should be directed to providing adequate Speech and Language Therapy and

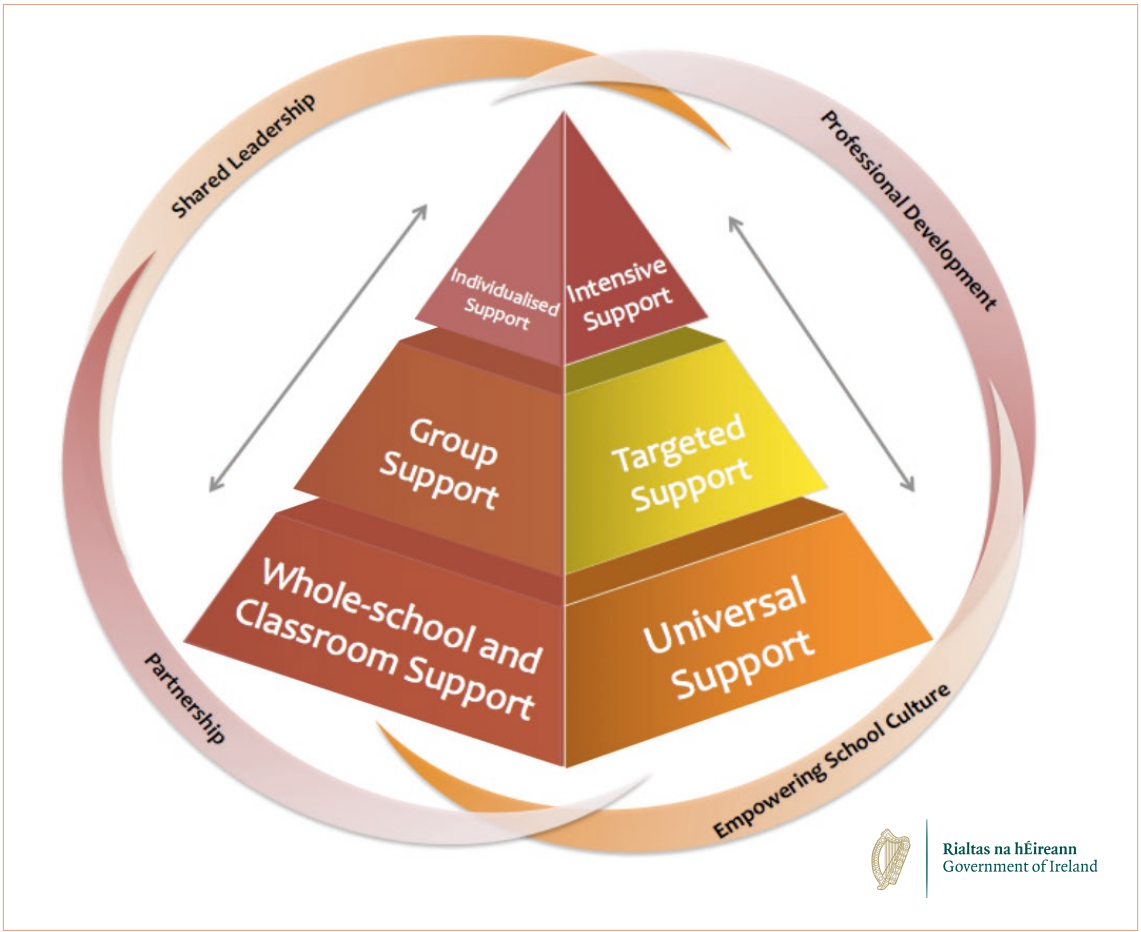
Occupational Therapy to support the inclusion of children with Autism Spectrum Disorder (ASD) in Irish schools (Daly et al., 2016, p. 101). Increasingly there is a recognition that teachers require the consistent and ongoing support of therapeutic disciplines in meeting the needs of the children in their classes, to support inclusion in general and not just targeted at behavioural or socio-emotional needs. The changing classroom environment, whereby the role of the teacher is increasingly focused on collaborating and working with other professionals, represents a fundamental shift in what was perceived as the traditional role of the teacher. Collaborative practice allows for different perspectives to contribute to the development of strategies to support the child's learning and development, which facilitates collective input from all professionals involved in the process (Hargreaves et al., 2012). The need for a new shift in inter-professional practice is warranted that is founded on a shared model of practice. It is clear from the tiered-model examples given here, that the education and ELC sectors have developed processes designed to provide a continuum of support. However, the current models are limited in scope as they focus on specific aspects (for example, behaviour) and are discipline-specific. As such, the collaborative, inter-professional aspect is as yet underexplored. Meanwhile, the role of the fuller health-education team that includes the Occupational Therapist and Speech and Language Therapist is as yet unclear. For example, as noted in the AIM model, therapeutic interventions are viewed as specialist and are not seen as part of the Universal approach in Level 1. There is a need to expand these models of inclusion now, to explore, develop and test a therapy model of school-based practice across all tiers and levels, to be able to provide the right support at the right time.

2.6 Demonstration Project Model: Aims and Objectives

The Demonstration Project is designed to be a new tiered model of therapy service provision in the education sector. It moves away from traditional direct 1:1 models of remedial therapy provision, and instead prioritises providing consultative collaboration services which are an evidence-based approach in school-based therapy practice internationally (Hanft and Shephard, 2008). Following best practice, this continuum-of-support model adopts a whole-school, targeted and intensive approach when working with educators to respond to the child's abilities, and needs to enhance inclusion and participation (see Figure 2.6). Internationally, collaborative consultation is where therapists work in collaboration with school staff to develop capacity and is focused on teamwork, whereby the school therapist works to understand the roles of the classroom staff and teacher, and vice-versa.

The proposed model of support outlined by the NCSE (2017) alongside the knowledge base from existing models from NEPS, NBSS and SET, served as the basis for the development of this proposed model for therapy support, which was outlined at the outset of the Demonstration Project and presented to the educational settings of CHO 7 (Demonstration Project Working Group, 2017).

Figure 2.6: Multi-Tiered Continuum of Support



2.6.1 Aims of Demonstration Project

According to Demonstration Project documentation, the project aimed to "build capacity and inclusion in a range of educational settings through a partnership approach between school staff and project Speech and Language Therapists and Occupational Therapists" (Demonstration Project documentation). This would be achieved by therapists working together with a project team, comprising relevant school staff, parents/guardians and students, to agree on the level of intervention required across the tiered continuum of support.

Table 2.2: Demonstration Project Aims

- To develop and evaluate a multi-tiered continuum-of-support therapy model which aims to build capacity and inclusion in educational settings.
- To support the learning, engagement and participation of all children/students by facilitating access to all aspects of the curriculum in ELC/school settings.
- To explore and develop effective models of collaborative partnership between in-setting/school project therapists, ELC/school staff, the Department of Children and Youth Affairs, the Department of Education and Skills and the Department of Health and HSE Services with a view to achieving better educational outcomes for children/students and their families.
- To explore and develop models of effective cross-sectoral collaboration and pathways to ensure clarity of roles and optimal use of resources between in-setting/school therapists and therapists in statutory and non-statutory organisations.

By employing this tiered model, the project sought to assist schools/ELCs to develop their capacity to support children with therapy needs, while also focusing on early identification and intervention. In this context, the pilot aimed to establish more significant linkages between pre-school and primary school therapy support interventions in the associated schools and pre-schools who are participating in the pilot. The aims of the Demonstration Project are sub-divided into aims for ELC settings and aims for schools to reflect the unique nature of ELC settings and schools, but are combined here for clarity (see Table 2.2).

2.6.2 Describing the Tiered Model of Therapy Service Provision

According to the Demonstration Project, the tiered model has specific characteristics that differentiate it from traditional therapy service provision. As noted in the aims of the project, it focuses on supporting learning, engagement and participation of students by facilitating access to the curriculum, by working across a multi-tiered model at one time. However, this does not mean therapists work directly with children to achieve this. Based on the evidence of outcomes from working with collaborative approaches,[10] therapists work alongside educators to accomplish these aims through knowledge-sharing and capacity building at each tier.

10 See literature review section 3.

2.6.2.1 Tier 1: Whole-School Support (Whole School and/or Classroom Approach)

Through knowledge-sharing and working collaboratively with school staff and families, the project therapists aimed to enhance staff capacity to create more inclusive educational settings for all students. For example, collaboration could involve teachers and project therapists working at a whole-school/class level, delivering staff workshops, in-services and also the sharing of resources. The focus of the workshops and in-service was to support inclusion by focusing on sensory, physical, social, language, communication and cultural needs and opportunities in the educational environment. Tasks such as supporting the implementation of the curriculum were identified in the description of the Tier 1 approach. They included support for the primary language curriculum and objectives of Aistear, as examples.[11]

Table 2.3: Tier 1 – Core Themes and Tasks Identified in Demonstration Project

The following materials provide some evidence for the approach taken by the Demonstration Project for Tier 1	
Demonstration Project Actions document	Therapists to work with management to review whole-school and classroom OT and SLT supports; to identify, plan and implement OT/SLT targets for whole-school and classroom support; to provide training and information to staff and parents to support all students participate to the best of their ability in the learning environment
Demonstration Project information and frameworks for educational settings[11]	Focus on Aistear/and school curriculum, and specific areas of sensory, physical, social, cultural, communication/language learning opportunities, self-regulation, environment depending on identified targets, including for example, CPD on speech, language and communication needs, self-regulation, promotion of communication friendly schools, environmental analysis for access, and technology Information and support, parents engagement
Demonstration Project PowerPoint slides for information sessions to sites	OT: Supporting children to participate successfully in the daily tasks that happen in school and classroom, e.g. school-work, life skills, self-regulation, leisure, transitions SLT: support students develop their speech and language communication skills, e.g. develop attention and listening, expression, understand oral information, and use of vocabulary, social communication Whole-school support: teacher CPD, parent information, adapting environment, on-site observations, ongoing strategies and support for educators
Interim Process and Procedures document: NEPS and Demonstration Project Therapists, March 2019	Training, mentoring and coaching whole staff and groups of teachers, and engaging in collaborative planning and direct work with teachers in order to promote evidence-informed best practice, early intervention/ preventative approaches to improve OT and SLT outcomes within school settings and practice

11 Both the Framework for Schools and the separate Framework for Early Years are represented in full in Appendix D.

2.6.2.2 Tier 2: Targeted School Support (Targeted or Group Approach)

Students who require additional supports to those provided at Tier 1 would be supported in Tier 2 to access the curriculum better and participate in the learning environment through differentiated instruction. Tier 2 would be guided by collaborative consultation between school staff and the project therapists. Interventions, strategies and supports at Tier 2 would be targeted towards identified needs and would be teacher-led interventions, following training and support.

Table 2.4: Tier 2 – Core Themes and Tasks Identified in Demonstration Project

The following materials provide some evidence for the approach taken by the Demonstration Project for Tier 2	
Demonstration Project Actions document	Therapists to work collaboratively with school staff and parents in identifying and supporting groups of students with ongoing OT/SLT needs in learning environment To provide targeted support for teacher-led interventions, e.g., training and guidance on specific strategies/programmes, skills, coaching etc.
Demonstration Project information and framework for educational settings	Differentiated experiences to support better participation in learning environment via collaborative consultation, to provide practitioner-led (i.e. educators) interventions following training and support Focus on specific areas of sensory, physical, social and cultural environment, communication/language learning opportunities and self-regulation for children with additional support needs Information and support: development of evidence-informed collaborative programmes and strategies to support engagement with curriculum, e.g., speech, language and communication needs, motor, self-regulation, social engagement, consultation and training Parent engagement
Demonstration Project PowerPoint slides for information sessions to sites	OT: Supporting children to participate successfully in the daily tasks that happen in school and classroom, e.g. school-work, life skills, self-regulation, leisure, transitions SLT: support students develop their speech and language communication skills, e.g. attention and listening, expression, understand oral information and use of vocabulary, social communication Targeted support: teacher-led groups, parent workshops, on-site observations, and collaborative identification of need, ongoing skills coaching for staff
Interim Process and Procedures for Liaison and collaboration between NEPS and the Demonstration Project Therapists, March 2019	For additional support and school support plus (Tier 2 and 3 equivalents), both NEPS and Demonstration Project therapists work with staff, parents and students who require additional support beyond that required at classroom level

2.6.2.3 Tier 3: Individualised School Support (Intensive Approach)

The project therapists would, in collaboration with school staff, facilitate individualised interventions for students who require additional supports and accommodations to enable the student to access the curriculum and develop specific skills. Support at Tier 3 aimed to contribute to existing intensive support provided by the school and may have included liaising with external agencies (for example, HSE Primary Care) and support for transition pathways for students.[12]

Table 2.5: Tier 3 – Core Themes and Tasks Identified in Demonstration Project

The following materials provide some evidence for the approach taken by the Demonstration Project for Tier 3	
Demonstration Project Actions document	Therapists to work collaboratively with school staff and parents in identifying and supporting students who have significant and persisting needs and require additional supports to Tier 1 and Tier 2. To provide individualised OT/SLT recommendations and resources for integration into the school and home environments, in collaboration with school staff/other agencies/parents. To provide support and guidance regarding referral to/liaison with other agencies; to support teacher update Student Support File
Demonstration Project information and framework for educational settings	Therapists will facilitate individualised interventions in collaboration with practitioners, to support children be confident and competent learners, via contributing to existing intensive support already provided and liaising with other agencies. • identification of children's significant and persistent OT/SLT needs • multi-disciplinary consultation • collaborative target-setting with practitioners • working directly with practitioners and family on OT/SLT needs • support in developing and implementing IEPs • support for transitioning pathways to other services Focus on specific areas of sensory, physical, social, cultural, communication/ language learning opportunities, self-regulation, and environment for children with significant and persistent support needs, to identify meaningful learning experiences.

12 Demonstration Project on In-school and Early Years Therapy Support: Overview of Demonstration Project (Project document).

The following materials provide some evidence for the approach taken by the Demonstration Project for Tier 3	
Demonstration Project PowerPoint slides for information sessions to sites	OT: Supporting children to participate successfully in the daily tasks that happen in school and classroom: e.g. school-work, life skills, self-regulation, leisure, transitions SLT: support students develop their speech and language communication skills: e.g. develop attention and listening, expression, understand oral information, and use of vocabulary, social communication Individualised support: supporting links between school and outside agencies; collaboration with specific parents; individualised recommendations; collaborative working with teachers to support specific students
Interim Process and Procedures for Liaison and collaboration between NEPS and the Demonstration Project Therapists, March 2019	For additional support and school support plus (Tier 2 and 3 equivalents), both NEPS and Demonstration Project therapists work with staff, parents and students who require additional support beyond that required at classroom level

2.6.3 Roles of Schools and Project Therapists at Each Tier

The role of participating ELC and school settings were defined in early project documentation alongside the roles the project therapists at each tier of the continuum of supports.[13] Regarding Tier 1, this included facilitation of meetings with relevant staff and therapists during the year, supporting the implementation of the Tier 1 targets, and facilitating CPD activities that would be planned. For Tier 2, this expanded to include assisting the project team (including school staff) to identify students who required additional support. For Tier 3, the school role now involved a more individual focus for students who were not achieving at Tier 1 and 2. This involved the role of monitoring, reviewing and documentation of student progress in conjunction with the project therapist. The school role for all three tiers included supporting the partnership between the project team and school staff, and involving parents.

For the therapists, the roles at each tier align with the aims of each tier. These included focusing on collaborating with management and the school community to implement the project, shared identification of needs, provision of training for teacher-led interventions (at Tiers 1 and 2), and provision of recommendations and resources for individualised therapy at Tier 3 (see Table 2.6 for detailed role outline).

13 Demonstration Project on In-school and Early Years Therapy Support Project Aims (Project Actions Document).

Table 2.6: Roles of Schools and Project Therapists at Each Tier[14]

Tier 1: Whole-school support (whole-school and/or classroom approach)	
School	**Project therapists**
• To facilitate planning meetings with relevant staff and project OT/SLT during the academic year. • To support the implementation of whole-school and classroom project targets in line with relevant school plans. • To facilitate CPD/learning activities for the whole staff and/or parent(s)/guardian(s) as agreed by the school project team and project OT/SLT.	• To work with management and staff in reviewing current whole-school and classroom OT/SLT supports, as appropriate. • To work with management and the school community in identifying, planning and implementing OT/SLT targets for whole-school and classroom support. • To provide training and information for school staff and/or parent(s)/guardian(s) to support all students to participate to the best of their ability in the learning environment. • To maintain appropriate records of support provided, in school and project office.
Tier 2: Targeted school support (Targeted or group approach)	
School	**Project therapists**
• to facilitate collaboration between school staff and the project OT/SLT to identify students who require additional supports to those already provided by universal school support • to facilitate relevant school staff to work in partnership with the project OT/SLT to plan and implement agreed targeted supports • to monitor, review and document students' progress, in conjunction with the project OT/SLT • to inform parent(s)/guardian(s) in relation to planned targeted support • to open/contribute to the Student Support File.	• to work in collaboration with school staff and parent(s)/guardian(s) in identifying and supporting groups of students with ongoing OT/SLT needs in the learning environment • to provide targeted support for teacher-led interventions, for example, training, guidance on specific strategies/programmes, skills coaching, etc. • to review students' progress in collaboration with school staff and/or parent(s)/guardian(s) • to support teachers to update the Student Support File, as required • to maintain appropriate records of support provided, in school and project office.

14 Demonstration Project on In-school and Early Years Therapy Support Project Aims (Project Actions Document).

Tier 3: Individualised school support (Intensive approach)	
School • to obtain informed written consent from parent(s)/guardian(s) • to open/contribute to the Student Support File • to facilitate collaboration between school staff and the project OT/SLT to identify students who require individualised support in the learning environment. This is in addition to the supports provided at the universal and targeted levels • to facilitate relevant school staff to work in partnership with the project OT/SLT to plan and implement agreed individualised supports • to monitor, review and document individual students' progress, in conjunction with the project OT/SLT.	**Project therapists** • to ensure that informed written consent has been obtained from parent(s)/guardian(s) for intensive school support • to provide support and guidance on identifying students who have significant and persisting needs and require additional supports to those provided at the universal and targeted school support levels • to provide individualised OT/SLT recommendations and resources for integration into the school and home environments, in collaboration with school staff, parent(s)/guardian(s) and relevant external agencies • to provide support and guidance regarding referral to/liaison with external agencies, as required • to support teachers to update the Student Support File, as required • to maintain appropriate records of support provided, in school and project office.

2.6.4 Roles of the HSE in the Demonstration Project

The HSE role in the Demonstration Project was to provide clinical support to the project therapists. Moreover, the HSE was tasked with assisting the overall implementation of the model of delivery in ELC settings and schools. Roles included onward referral, liaison with local services and additional services such as NEPS, amongst others. As the Demonstration Project is supplementary to existing services, the project aimed to focus on developing more significant linkages between educational and therapy supports. It was anticipated that protocols would be established and agreed as to how the Speech and Language Therapy and Occupational Therapy services in pilot schools would interact with existing HSE services, and how they would interact with school staff (Demonstration Project Working Group, 2017).

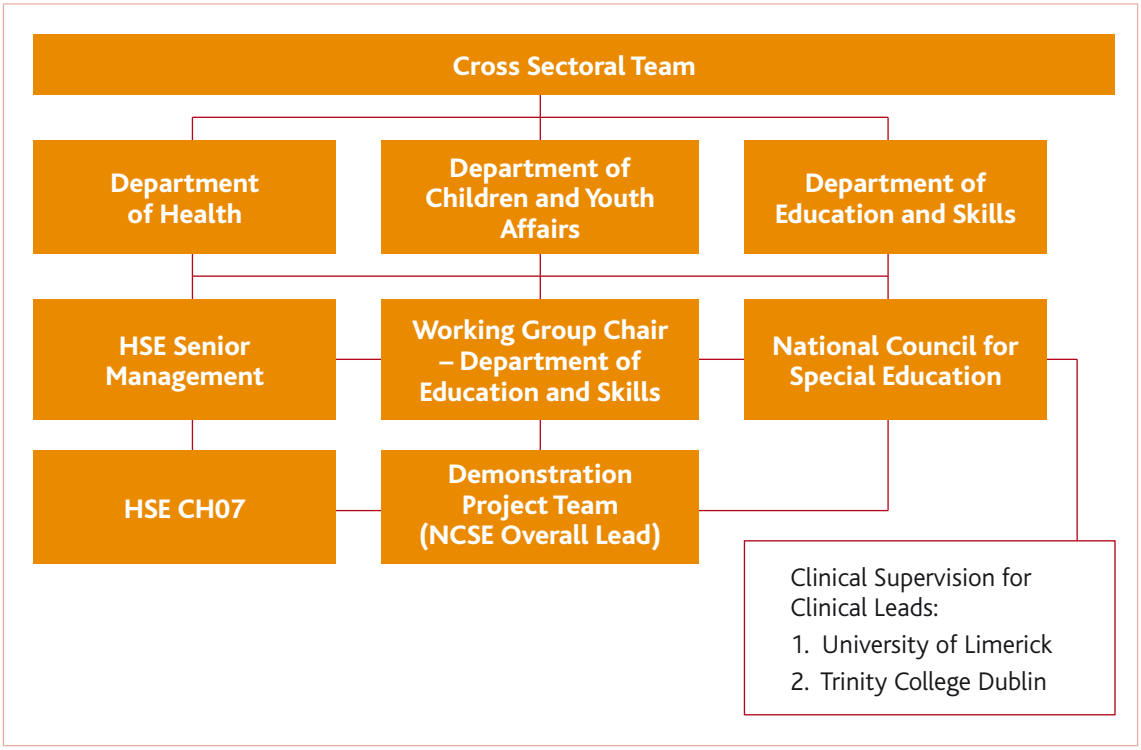
The evaluation of the Demonstration Project aimed to determine the effectiveness of the project. This included assessing outcomes for the educational settings regarding the impact on the capacity to support children and families. The evaluation also included a process element to determine how the service design and delivery model was operationalised. The following Section 2.7 documents the project establishment and scope during the early stages of implementation.

2.7 Demonstration Project Working Group: Pre-Project Implementation

As noted earlier, the Cross-sectoral Team established a Working Group to manage and coordinate the Demonstration Project, which was led by the DES and included representatives from the DES, DCYA, DoH, NEPS and the HSE. The role of the NCSE was to lead the Demonstration Project. The HSE was tasked with assisting the overall implementation of the model of delivery in ELC settings and schools[15] (see Figure 2.7). In preparation for this Demonstration Project, the Working Group was engaged in a range of preparatory activities. These activities included:

- identifying the number of management posts and balance of Speech and Language Therapists, and Occupational Therapists to support the project
- developing a recruitment and employment framework to support the employment of therapy staff
- selecting a Region in which the Demonstration Project would be piloted
- selecting the schools for inclusion in the Demonstration Project
- identifying care pathways between schools, school-based therapists and existing HSE services.

Figure 2.7: Governance Structure for the Demonstration Project



15 Demonstration Project on In-School and Early Years Therapy Support, Project Plan 2018-2019, p.3.

2.7.1 Posts to Support the Project

Management Posts

A project team was appointed for the implementation of the Demonstration Project. The Demonstration Project Management Team was designed to comprise:

a) one project leader

b) one project manager

c) one executive officer

d) two clinical leads representing both the discipline of Speech and Language Therapy and Occupational Therapy[16]

e) HSE senior managers from the discipline of Speech and Language Therapy and Occupational Therapy.[17]

The NCSE was supported by the HSE, who were responsible for the recruitment of therapy staff and the provision of clinical support to the therapists.

Therapy Posts

The HSE advised the Working Group concerning the therapy posts required. The level of clinical competency required for this role in the HSE was established as Senior Grade, with support from Staff Grade for implementation of interventions. The effective therapist in the senior role was described as having three or more years' clinical experience in managing a mix of caseloads, decision-making and triage, including screening clinics, initial assessment and provision of individual and group level programmes. Also, desirable attributes associated with recruitment of senior therapy staff related to having experience in working with education staff in a range of school settings (Demonstration Project Working Group, 2017). The HSE advised the Working Group that Staff Grade therapists would have had placements across a variety of settings and caseloads, which may or may not have included schools, but that they had received training in their basic therapy qualification on each of the specific approaches that will be required to support the rollout of the Demonstration Project (Demonstration Project Working Group, 2017).

Initial targets stated that the Senior and Staff Grade posts would work together to deliver the services to five schools per post, or ten schools per one Staff Grade and one Senior Grade posts. However, following consideration of the various combinations of post numbers that could be achieved within the funding level provided, the Working Group in 2017 agreed that the balance of post distribution to support the Demonstration Project would be 15 Speech and Language Therapists and nine Occupational Therapists (Demonstration Project Working Group, 2017). Due to the additional requirements that came with the added inclusion of the ELC sector

16 Role of the clinical leads was to ensure clinical excellence in line with best practice and evidence informed research, and facilitate peer support and mentoring among other tasks (Project Action Plan, 2019).

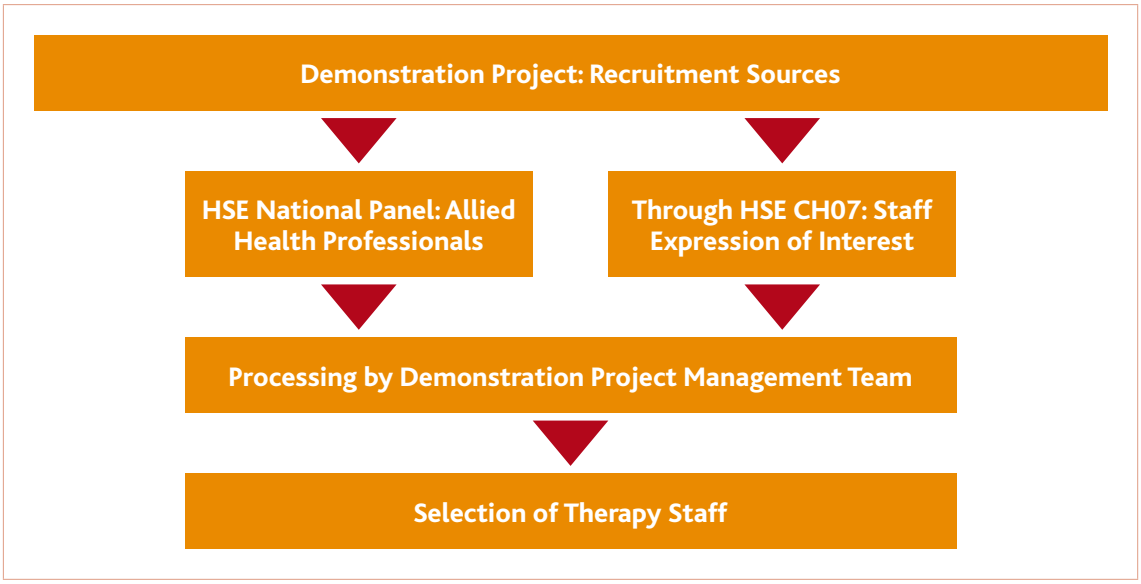
17 The role of the therapy managers was to provide line management, alongside clinical and operational supervision, and alignment with existing HSE services (Project Action Plan, 2019).

in 2018, the HSE subsequently agreed to increase the recruitment numbers to up to 31 therapy posts. The final plan, therefore, was to recruit 19 Speech and Language Therapy posts (nine Senior Grade and ten Staff Grade therapists) and 12 Occupational Therapy posts (five Senior Grade and seven Staff Grade therapists) to work on the Demonstration Project.

2.7.2 Recruitment and Employment Framework

To devise the bespoke recruitment framework, the Working Group examined the existing mechanism for the employment of therapy staff, including the centralised, national recruitment process (panel system) operated by the HSE in Ireland.[18] The HSE agreed to recruit/assign the 31 therapy posts to work on the Demonstration Project. Also, the assignment of two HSE therapy managers to the project was approved, with the establishment of a Memorandum of Understanding setting out the agreed arrangements in place to provide for reimbursement of salaries and costs for the personnel assigned to the project and for the provision of non-pay costs associated with the project. The HSE committed to recruit to and backfill these posts from CHO 7 or other areas to ensure that the in-school therapy project was not displacing existing services (Demonstration Project Working Group, 2018). The recruitment of therapy staff for the Demonstration Project commenced in April/May 2018, and by October 2018, 28 out of 31 posts were filled.[19]

Figure 2.8: Recruitment Model (Bespoke to the Demonstration Project)



18 https://www.hse.ie/eng/staff/jobs/recruitment-process/how-to-apply.html.

19 Information received from focus group with NCSE management team, January 2019.

2.7.3 Selection of Region

In selecting a region, or regions, in which the pilot should take place, the Working Group was required to have regard to a range of criteria that would ensure that within the selected region in which the pilot would take place, the following criteria could be fulfilled (Demonstration Project Working Group, 2017):

- requirement to test the in-school therapy model in an urban and rural location
- should be able to provide for a broad representative sample of schools, as set out below on school selection criteria
- should be accessible to be supported from management services
- have the capacity to be able to recruit sufficient Speech and Language Therapy and Occupational Therapy posts
- minimisation of travel time: clusters of schools can be established within a defined region
- should not overlap with existing in-school Speech and Language Therapy pilot projects
- demonstrate capacity to coordinate with existing HSE Services
- demonstrate capacity to bring all schools together for CPD events
- should, if possible, be in an area which has been reconfigured under *Progressing Services for People with Disabilities*.

Following consideration of all of the factors involved, it was agreed that the Demonstration Project would take place in CHO 7. Within this region, two hubs were to be established, from where the Project Team would coordinate and operate their service: Nesta in Kylemore Road, Dublin and the Kildare Education Centre.

2.7.4 Selection of Schools for Inclusion

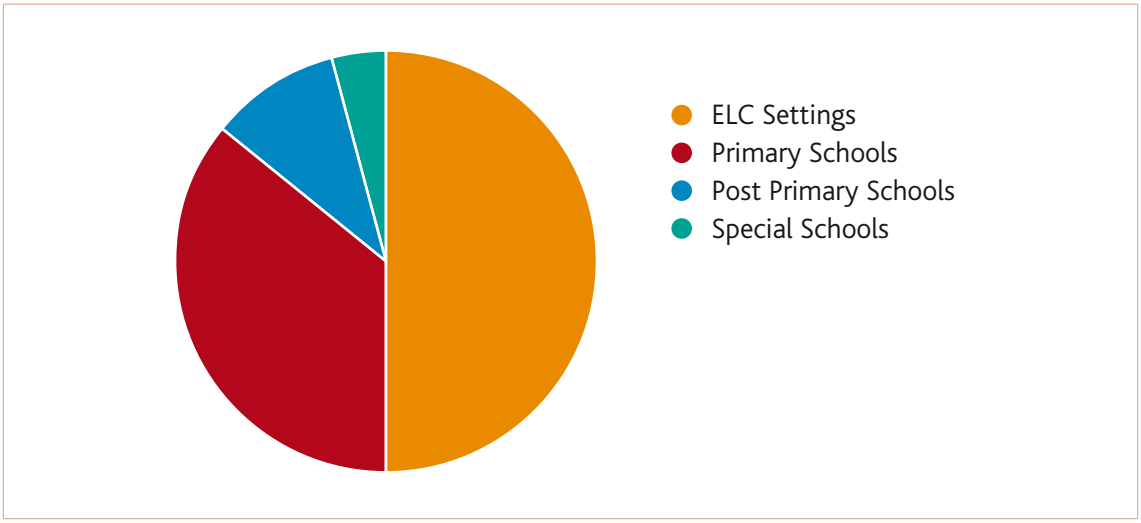
The Education Research Centre (ERC) were asked to select 75 schools (54 primary, 15 post-primary, 6 special schools) for invitation to participate in the project. Factors considered in the selection of schools included school size, urban/rural location/gender and also the following (Demonstration Project Working Group, 2017):

- balance between Primary and Post-Primary School Sectors (60 primary national schools [including 5 special schools] 15 post-primary)
- inclusion of Disadvantage/DEIS status schools
- medium of Instruction (Irish)
- special schools (not supported by existing dedicated Speech and Language Therapy service)
- sector and ethos

- primary and post-primary schools with special classes (excluding Specific Speech and Language Disorder (SSLD) classes)
- school(s) with Early Intervention Special Class
- capacity to group schools into clusters of five (approximately) schools.

Working with these sampling criteria, the ERC randomly selected 75 schools for participation in the project. Following the support of the ERC and DCYA, an additional 75 pre-schools were added to the project. These were identified by the DCYA as being linked to or feeder schools to 54 primary schools in the project. Settings were invited to participate in the project voluntarily (Demonstration Project Working Group, 2018). In total, a combined 150 settings were invited to participate in the Demonstration Project by the NCSE project manager both verbally and in writing (see Appendix H).[20]

Figure 2.9: Number of Settings (by Setting Type) Participating in the Demonstration Project



2.7.5 Allocation of Project Therapists to Educational Settings

Once the sites were identified, it was possible to determine the plan for allocation of therapists. With 150 sites and 31 therapists, each therapist was on average allocated a workload of 9.5 settings each, with Speech and Language Therapists being allocated approximately 7 settings each in contrast to the Occupational Therapists having an allocation of roughly 12 settings each. Participating schools and ELC settings were aggregated across four geographical areas, with responsibility for approximately 80% of settings (n=119) managed via the Dublin hub and the remaining 20% (31) of settings managed by the staff assigned to the Kildare hub.[21]

20 Information received from interview with project manager, January 2019.

21 Nesta, Kylemore Road, Dublin 15 and The Education Centre, Kildare Village.

2.8 Demonstration Project Initiation and Key Stages for Implementation

In preparation to commence work on the Demonstration Project, efforts were focused on establishing consensus on the content of the Tiered Model Frameworks. In particular, initiatives pertained to ensuring that these reflected not only the national curriculum but also specific areas of domain expertise in Speech and Language Therapy and Occupational Therapy. Furthermore, the full complement of stakeholders was actively engaged in a collective effort to ensure the necessary agreements and structures were in place. Work was put in place to engage schools and Early Learning and Care facilities that would go on to participate in the Demonstration Project (Demonstration Project Working Group, 2018).

The implementation of the project commenced on 13 August 2018 with the management team (as outlined in 2.7.1). It is important to note that the management team was active before August 2018. Before this time, the management team had been engaged in a range of preparatory activities. These activities included developing a recruitment process to support the employment of 31 staff, the development of a series of clinical frameworks, systems, procedures and policies that would support their work, and induction materials to ensure that they could begin work in schools as quickly as possible. The Demonstration Project commenced in September 2018 and ran for one school year (2018/19). The implementation plan for the Demonstration Project was divided into four stages, incorporating timeframes and associated actions.

2.8.1 Project Action Plan

The Project Action Plan was established at the outset and outlined actions for implementation and included project actions such as creating two project hubs, recruitment and allocation of therapists to settings and developing project frameworks (introduced earlier).[22] For Stage 1 (August to December 2018), a combined 28 actions were determined.[23] The responsibility for the actions resided primarily with the Project Management Team; however, some preparatory actions were assigned to the Project Lead and Assistant Principal Officer of the project as well as the HSE. For Stage 2 (January to April 2019), a combined 24 actions were determined.[24] Stage 3 (April to July 2019) was to focus on the continued implementation, with Tier 3 being addressed more explicitly. Stage 1 was primarily focused on implementing Tier 1, while the implementation of Tier 2 being more prominent in Stage 2, with Tier 3 being the focus of the project by the end of the school year.

22 Demonstration Project on In-School and Early Years Therapy Support, Project Plan 2018-2019.

23 Demonstration Project on In-School and Early Years Therapy Support, Project Plan 2018-2019.

24 Demonstration Project on In-School and Early Years Therapy Support, Project Plan 2018-2019. Stage 2: January-April 2019.

2.8.2 Project Procedures

The project plans included evidence of the governance procedures that were designed and included, for example, the development of recording systems, the development of protocols and pathways of referral between settings and services. Relevant standard operating procedures were to be developed alongside the establishment of project data gathering and recording systems. Other actions included the need to establish relevant processes for maximising ongoing relationship building and protocol development with HSE (CHO7) and Psychological Services, the continuation of CPD for therapists and ongoing clinical governance.

2.8.3 Therapist Induction

The Project Management Team developed and put in place an introductory induction programme for staff commencing on the project, in the absence of existing training programmes for the delivery of tiered models of therapy support. The management team populated this induction based on the skills and knowledge from within the team and from using existing workshops from other agencies. Also, workshops were to be provided by the DCYA, NCSE, NEPS and DES concerning curriculum, child protection, well-being initiatives, educational strategies, digital frameworks, the role of the different disciplines including SENOs and the inspectorate. Other workshops were designed for supporting therapy staff to engage in brainstorming ideas for implementing a tiered model in Irish school-based settings. All new therapy staff members were to be furnished with reading materials (book chapters, scientific articles and position papers) and resources (PowerPoint presentations developed to provide staff with an understanding of the context of the project and to situate it amongst the numerous and varied schemes of support available to schools). The written materials drew from some international and Irish examples of practice. They provided examples of the current state of the art in the provision of tiered models of therapy supports in schools. The discipline-specific clinical leads, discipline-specific therapy managers and the Demonstration Project leader were responsible for delivering the majority of training.

2.8.4 School/ELC Engagement

The primary phases of the engagement process with schools and ELCs included initiating contact with each setting, explaining the project, setting up project teams and conducting a needs analysis of each setting. The Demonstration Project undertook a range of actions to address school/ELC engagement to achieve this goal. The purpose of the school/ELC engagement phase was to increase awareness and understanding of the proposed project to stakeholders within participating schools and ELC settings (Demonstration Project Working Group, 2018).[25], The Project Management Team identified and developed a range of written resources that could be provided to staff from participating settings to support this process of engagement. This included resources such as information letters to school principals/ELC managers[26] and provision of materials to explain the tiered model to parents and educators. These materials

25 Information received from interview with project manager, January 2019.

26 Final letter to schools May 2018: Demonstration Project on In-school and Preschool Therapy Support.

were to be presented to the educational settings during introductory sessions at the start of implementation. Two initial information sessions for principals/managers of the 150 sites were held on September 13th and 18th 2018, when these resources were circulated to participant settings directly. A needs analysis of individual settings was planned, and a whole-setting evaluation survey designed for use on-site by the project team. Varied needs-analysis processes were intended to include:

1. identification of pupil numbers and record of any relevant diagnostic information
2. identification of staffing profile
3. identification of education setting profile (e.g. AIM level 7, special classes, involvement in existing programmes)
4. survey of staff to determine needs
5. observation of educational activities by therapists
6. survey/focus-group/discussion with parents
7. survey/focus-group/discussion with students.

2.8.5 Setting up Project Teams

The Demonstration Project documentation stated that the therapists would work together with a project team, comprising relevant school/ELC staff, parents/guardians and students, to agree on the level of intervention required across the tiered continuum of support.[27] One of the first actions planned for each therapist team was to help the participant settings establish a project team for the site, which was to include interested staff members. The project team was the term used to describe an operational group set up in each of the participant locations and was not explicitly defined, but was to include 'relevant school staff… who will work together to agree on a level of intervention required across the continuum of support'.[28] No documentation articulated the composition, membership, terms and conditions or roles and responsibilities of these teams.

2.9 Summary and Conclusion

This chapter describes the early development and establishment of the Demonstration Project. This commenced in 2016 with the Programme of a Partnership Government and was subsequently followed by the establishment of a Working Group to conceptualise and oversee the remit of the project. Once agreed, the Demonstration Project Team was appointed to develop governance processes and data management, and to facilitate recruitment and induction of therapists. The sites for the project were identified and subsequently, an implementation plan agreed. Finally, the Demonstration Project Stage 1 began in August 2018 and concluded with Stage 4, in August 2019.

27 Demonstration Project on In-School and Early Year Therapy Support Document (ND).

28 Demonstration Project Guide for Schools (NCSE), p. 2.

The evaluation of the Demonstration Project is an essential part of the development of the new model of therapy in-school service provision. It aims to determine the effectiveness of the Demonstration Project and to assess outcomes for the participating ELC and school settings concerning the impact on their capacity to support children and families. The evaluation also includes a process element to determine how the service design and delivery model was both developed and operationalised. The evaluation team were appointed in October 2018, when they began the process of data collection, and concluded with the evaluation in September 2019.

The following chapter will situate the Demonstration Project and the aims within the context of the international literature for school-based therapy models to set the scene for the evidence-based aspect of the Demonstration Project evaluation.

3. Literature Review

3.1 Introduction

The purpose of this section is to present a synopsis of relevant literature reviewed and analysed to inform the evaluation. The evaluation is tasked with evaluating the effectiveness of the Demonstration Project, which is to include a summary of therapy research evidence relating to tiered approaches to interventions in educational settings (NCSE, 2018). From Section 2, the concept of the model was introduced, and examples of current tiered approaches identified and described that have been implemented in Ireland to date. From the Demonstration Project documentation, new ways of working were described using terms such as collaborative consultation, coaching, differentiation and accommodation, for example. This section also aims to explain what these terms mean from a school-based therapy context and the therapy evidence base that informs the Demonstration Project model as it has been described and defined to date.

Background research evidence was synthesised to provide core information on the research evidence base that underpins the tiered model of service delivery in school-based therapy practice worldwide. A methodological search strategy was identified at the beginning of the study, which included a review of key electronic databases.[29] The strategy was adapted for each database and limited by date to peer-reviewed papers published between 1990 and 2018. There were no limits applied on location, although texts had to be available in English. Studies were included if they reported evidence from designing, delivering or summarising evidence of a tiered approach in school-based therapy practice. The reference lists of all of the included studies were also reviewed for key references. Policy literature related to the use, organisation and deployment of resources in education contexts to effectively meet the needs of all learners in inclusive contexts, was also examined.

The search identified studies that reported on a systems approach to inclusion in educational settings as the underlying principle of service delivery. The majority of studies reported on qualitative evidence concerning the implementation of school-based therapy services from the educators' and therapists' perspectives, alongside studies of quantitative outcomes and impact on staff, with some studies of impact on children and parents. Notably, the majority of studies were not inter-disciplinary across Speech and Language Therapy and Occupational Therapy but instead focused on the therapist-educator relationship. Most studies reported on regional projects and did not represent data from significant, government-funded programme development. Few studies examined outcomes from a child's or parents' perspective, however, which is noted as a challenging area warranting further investigation in research (Anaby et al., 2018). The majority of effectiveness and impact studies to date have been conducted in educational settings based on examining the effectiveness of a specific intervention at a particular tier. Few studies examined the process of implementing a tiered model, with a large Canadian study (Partnering for Change, P4C) being the exception (Missiuna et al., 2015).

29 Scopus, Web of Science, EBSCO-CINAHL, ERIC, PsychINFO, Embase, PubMed, SpeechBITE.

A summary of findings from this data is presented here to provide further comparative data for the Demonstration Project, in relation to implementation of a tiered model and examples of what constitutes each tier. The section includes an analysis of similarities and differences between school-based therapy practice models internationally and the Demonstration Project, to determine its unique features.

3.2 School-Based Therapy Practice in Tiered Models of Service Delivery

School-based therapy practice differs from more traditional forms of therapy provision, in that it is underpinned by an educational model rather than a medical one, which requires a unique set of knowledge and skills for effective service delivery. In both Occupational Therapy and Speech and Language Therapy, the tiered approach in educational settings is described as a model of service delivery whereby therapeutic interventions become increasingly specialised, intense and individualised as the child's needs increase (Ebbels, et al., 2019). Typically, this is described as a three-tiered or staged approach, where Tier 1 is universal, Tier 2 is targeted and Tier 3 intensive, and is described consistently as a continuum of service delivery (Ebbels, et al., 2019). It has also been documented that the tiers are demarcated differently between therapy and educational settings across different studies in the UK, USA and Canada see Hutton, Tuppeny and Hasselbusch, 2016; Ohl et al., 2013). For example, an educational perspective of Tier 1 focuses on characteristics of the child, whereas the therapy perspective focuses on the type of intervention. Consequently, there is a variance in how the tiered model is described across different studies. From an analysis of the core characteristics; however, it is clear that they are all referring to a similar tiered approach that is consistent across the studies. Table 3.1 presents a summary synthesis of the tiered model from the review of this international evidence, consisting of core principles relating to: (i) characteristics of the child, (ii) type of intervention, (iii) relationship to educational need and (iv) focus of delivery. This aligns clearly with figure 2.6 for the Demonstration Project multi-tiered model of support.

Table 3.1: Describing the Tiered Approach as an Integrated Model of Therapy Practice

Tier	Characteristics of the child	Type of intervention	Relationship to educational need	Focus of delivery
Tier 1	Education for all	Universal/universal design for learning	General curriculum	Collaborative consultation, coaching, capacity-building, shared problem-solving and delivery of interventions
Tier 2	For those at risk	Targeted	Differentiated curriculum	
Tier 3	For those with identified special needs	Intensive	Accommodation or individual education-oriented interventions	

Similar to the Demonstration Project model, the approach at its heart focuses on collaborative consultation and capacity building that involves partnership, empowerment and shared leadership between therapy and educational personnel.[30] Working in collaboration with school staff to develop capacity is a core characteristic of a tiered approach across international literature. The collaborative consultation approach is adopted for teamwork, whereby the school therapist works to understand the roles of the classroom staff and teacher, and vice-versa (Hanft and Shapherd, 2008).

In therapy literature, collaborative consultation is defined as being different to providing training: "it involves joint planning and decision-making about the priorities and method of delivery of an intervention and is different from training or directing an assistant where the (therapist) may take on the role of 'expert'".

The aim of this approach is to capacity-build to support each team member to do their jobs more effectively, from an educational/academic/therapy perspective.

In the case of school-based practice, the expected outcomes related to increased confidence, knowledge, skills for educators and school staff (Bundy et al., 2008). Across the therapy professions, the development of a collaborative consultation type of model has become more prevalent in recent years. It is viewed as an effective alternative to direct therapy intervention that is, however, complex and multidimensional. As a strengths-based way of working, collaboration is highly dependent on positive relationships and mutual respect, and sustained engagement in the educational setting. Overall, the therapist joins with the school staff to be a supporter of participation and inclusion.

Evident in international literature and the Demonstration Project framework is the focus on universal approaches to learning at Tier 1, which involves designing interventions that focus on capacity building for educators to benefit all students. For Tier 2, differentiated instruction is the approach that is applied when the universal approach is not meeting needs[31] and refers to the adaptation of the curriculum for small groups of students. Here, the therapist and educator collaborate to determine potential practices or strategies that would be reasonable alternatives to conventional educational methods. Differentiated instruction involves going beyond the universal approach and exploring other options to ensure the child experiences success in school participation. This may include observation to determine need in context, and to differentiate how each child functions compared to each other in small groups (AOTA, 2011).

Working from a needs-led perspective rather than focusing on diagnostics, involving *Dynamic Performance Analysis* (in the Occupational Therapy literature) or *Dynamic Assessment of Language* (Ram et al., 2013) (in the Speech and Language Therapy literature), both of which are observation-based assessments of performance in context (Missiuna et al., 2012), and aim to assess children's potential for learning by systematically modifying materials presented

30 Demonstration Project on in-school and early years therapy support document for schools, 2018; see also NCSE (2017).

31 Demonstration Project on in-school and early years therapy support document for schools, 2018.

(Lidz, 1991; Hasson and Botting, 2012). In this approach to assessment, the therapists work more at a pragmatic level to observe events and participation in the classroom or schoolyard during different classes, depending on the challenge identified using checklists or questionnaires to analyse the environments. The analysis supports discussion with the classroom staff then on potential solutions, considering the curriculum demands and the class needs and priorities. Through collaboration, the potential solution is planned, and a decision made as to who is responsible for implementing it, when, where and how often. It is a trial and error system of shared problem-solving in a strengths-based way. Notably, this needs-led assessment may result in a Tier 1, 2 and/or 3 intervention depending on the outcome.

3.3 School-Based Tiered Models: International Evidence

There are many examples of school-based therapy practice in other countries such as the USA, Canada, New Zealand, UK and Australia, that utilise a three-tiered approach, like the new Demonstration Project model.

In the USA, therapists have worked in schools. They have been employed directly by the education sector for many years, primarily for addressing special education needs, under the Individual with Disabilities Education Act [IDEA] (2004).[32] Therapy provision falls within the remit of providing for children with exceptional needs, connected to the development and implementation of an Individual Education Plan (IEP), and funded by health insurance. Within the IDEA was a commitment to a new approach called Response to Intervention (RtI), which reflected a more universal, tiered perspective in educational policy and practice. RtI is a government-led initiative adopted nationally across the states which aims to provide early, systematic and appropriately intensive assistance to children with language, learning and behavioural needs. It consists of common features of using evidence-based universal methods for all students, alongside universal screening for early identification of those at risk. Therapists are now trying to incorporate a whole-school tiered approach as a new service model, which takes time to implement (Handley-More et al., 2013). In a scoping review of models of school-based services for children with a disability, researchers found that RtI was the most frequently cited model of provision in the literature (Anaby et al., 2018). Evidence from therapists is emerging to date on this new way of working. In a survey of Occupational Therapists involved in RtI in 2014, more than 50% reported the most significant barrier to implementation was the lack of understanding of Occupational Therapy amongst educational staff, in addition to a lack of support for moving away from a referral model (Cahill et al., 2014). In contrast, the new Irish initiative begins by removing the referral-driven traditional system, while bringing therapists formally into the education system under the direction of the NCSE. The model for the use, organisation and deployment of additional teaching resources in schools in Ireland and in ELC settings reflects a continuum-of-support framework, which also aligns with the tiered model of therapeutic support (Department of Education and Science, 2007).

32 *The Individuals with Disabilities Education Improvement Act of 2004*. USA. Retrieved from https://sites.ed.gov/idea/.

In the UK, therapists are employed primarily by the health sector and work in partnership with the education sector to provide services within school settings, but not from a tiered-model approach. It is common for Speech and Language Therapy and Occupational Therapy services to be commissioned to schools based on service level agreements, or funding from several different services, both public and private. Therapists can also be employed directly by the schools based on a private arrangement (RCSLT, 2011). A recent report of a school-commissioned Speech and Language Therapy service found that school staff valued the opportunity to work closely with the therapist, and a consistent and ongoing relationship was essential to understand each other's roles (White and Spencer, 2018). However, there is an example of a tiered model of therapy provision. One Occupational Therapist developed a local initiative to pilot and implement a tiered model in one Trust area founded on the need to more effectively address health needs via a whole-school approach (Hutton, 2009). She found that regular, weekly presence in the schools over two terms was effective in impacting on capacity building of school staff, but school staff reported that they needed more long-term time commitments to embed this change. These examples from therapy practice in different settings demonstrate that the school-based practice is not consistent across the UK and differs from the Demonstration Project, as it is not being led by a central government initiative. Consequently, school-based therapy practices are not benchmarked across the UK, with different service provision models in existence.

Similarly, in Canada, there has been a shift away from traditional therapy models towards a new tiered model. This originated in the province of Ontario in 2010 when the Ministry of Health supported a new school-based initiative following a review of the school health services, which identified concerns such as long waitlists, poorly coordinated services with regional variations, and limited outcomes (Deloitte and Touche, 2010). This report led to the development of a new model of school-based practice in Occupational Therapy called Partnering for Change (P4C), as an evidence-based, school-based approach (Campbell et al., 2012). P4C represents the acronym that encompasses the four aspects: Capacity-building, Collaboration, Coaching in Context. These four themes were foregrounded because of their importance to the effectiveness of this approach (Camden et al., 2015). For the first time, therapists were based weekly in schools focusing on collaboration and capacity building based on a tiered approach, rather than on a referral model (Missiuna et al., 2015). The P4C programme has been shown to be effective at reducing waitlists and increasing generalisability of strategies for inclusion.[33] However, P4C was established and funded to address one specific group of children, those with Developmental Coordination Disorder (DCD), and therefore was restricted primarily to issues concerning functional difficulties related to school-based roles that are required of students. The Irish Demonstration Project from the outset is aimed to develop a model for all children, rather than some children, and is clearly aligned with a continuum-of-support framework, which as noted previously, is a key principle of both ELC and school provision in Ireland.

In Australia, therapy is traditionally provided in community settings or private practices with a lack of funding to date for school-based practice. This has resulted in different models of service provision being established across Australia, with government funding targeted only at particular groups of children such as those with diagnosed disabilities (Rens and Joosten, 2014). Despite

33 This was based on 15 Occupational Therapists working 1 day a week in 40 schools over three years.

its historical basis and the geographical variation in service models in operation, examples of dedicated provision of therapy services on a provincial basis within Australia are evident.[34] The relatively recent emergence of such examples of dedicated therapy service provision in schools suggests that a model or models of best practice may take time to be developed and fully implemented. In contrast, the Irish Demonstration Project, building on existing best-practice on the continuum-of-support framework in ELC and school settings, began with an overview of best practices internationally in tiered models and has established the tiered model as a framework within which to build the therapy service model (Figure 2.6).

In all these existing models of service provision for school-based therapy, multiple inter-sectoral stakeholders are involved. This can bring many challenges and additional barriers to successful school-based practice. For example, in a systematic review of health and education collaboration (Hiller, Civetta and Pridham, 2010), evidence shows that typical barriers can include issues related to service structures (where different team members are employed by different employees resulting in a lack of clarity around decision-making, pay scales or status), different case or workloads and different resources (due to different work patterns across educators and therapists, which results in difficulties in accessing each other). The necessity of having a clear organisational framework for service delivery has been identified as an essential feature (Anaby et al., 2018).

3.4 Evidence Base for Implementing the Tiered Model of Therapy Service Delivery

Although there are many examples of school-based therapy practices in other countries, few research papers have been published concerning the process of implementation of the tiered model. For example, Missiuna et al. (2017) note that despite the strong movement in the UK, Canada and the US towards using tiered models of service delivery for therapists, their P4C programme of research was the first study to systematically develop, refine, implement and evaluate such a model (Missiuna et al., 2017). The P4C programme outlines in detail the processes involved in implementing a tiered model of Occupational Therapy service within a school setting, and we have found no such equivalent programme of research in the Speech and Language Therapy literature. However, the RtI government-led initiative in the USA involves both disciplines. It is one programme that has a strong background of evidence concerning implementation since it was a federally funded initiative.[35] Although it was not a therapy tiered model of support, it provides evidence to inform the Demonstration Project as therapists have begun to develop their practices in this tiered model to provide a cohesive, multi-disciplinary service to schools (Handley-More et al., 2013). Therefore, both programmes have been examined to identify what constitutes good practice in implementing a tiered model in schools. While it is important to remain cognisant of the differing ELC and school setting contexts across jurisdictions internationally when considering any extrapolation from these research projects,

34 There are regional/provincial examples of dedicated services funded by the Department of Education providing Speech and Language Therapy, Occupational Therapy and Physiotherapy in schools, such as is available in the. Provision is based on specific criteria based on supporting the reasonable adjustments required by students, for further information see: https://education.qld.gov.au/student/Documents/ot-physiotherapy-brochure.pdf and https://education.qld.gov.au/student/Documents/aa-slprc-brochure-lr.pdf.

35 From 2007-2012, the US government established the federally-funded National Center on Response to Intervention (NCRI) which conducted a number of studies that provides some insight into implementation.

nonetheless they provide us with useful signposts for the ongoing development and potential expansion of the Demonstration Project in Ireland.

Both programmes approach implementation differently. RtI is typically introduced into schools gradually. In contrast, the goal of the P4C model was to implement the full model from the outset, so the scale of the project was planned to allow for this. In both RtI and P4C, essential features have been identified to the successful establishment and implementation of a tiered model of support:

- Both P4C and RtI programmes are established around principles of evidence-based practice and engage an implementation science approach to change practice (Odom et al., 2014).
- Both P4C and RtI programmes commit to high-quality evidence as a basis for the design of the model and the implementation. Data-driven decision-making and fidelity of implementation are core concerns to ensure each model is implemented according to the evidence-based principles they are built on (National Center on Response to Intervention, 2011).

The result is that some key implementation elements can be reported, and are outlined below. These relate to the assessment of school capacity to implement a tiered model, the establishment of a project team, screening and evaluation of need within sites, and implementing a tiered model that is flexible and is managed by the team.

3.4.1 Establishing Capacity in a School District – Experiences from the USA and Canada

In RtI, the implementation phase involves a process of establishing whether a school district or site has the capacity to implement the model.[36] The National Center on Response to Intervention (NCRtI) provides tools to support a local district self-assess capacity, including their available resources and planning needs. The assessment of capacity to implement RtI is based on implementation science approach, which is an evidence-based approach to service development and delivery and establishes four key stages of implementation: exploration, installation, initial implementation and full implementation.

3.4.2 Establishing a Project Team for Implementing the Model

In 2011, the NCRI conducted a review study across 42 participating RtI schools and identified core characteristics of successful implementation. Firstly, the establishment of a project team for each school was identified as an essential requirement. The role of this project team is to plan for RtI implementation, provide professional development opportunities and to review student screening and progress-monitoring data. Although a school-based project team was not central in P4C, the therapist was present on-site weekly to support the establishment of the

36 https://rti4success.org/sites/default/files/NCRTI_District_Rubric%20and%20Worksheet_061112.pdf.

model in collaboration with the school stakeholders. The role of the project team is to establish a framework for inter-professional collaboration that is central to such a project. From these projects, there is an acknowledgement that the success of such a project involves collaboration at both an individual and an organisational level (D'Amour et al., 2008). At the individual level, all members of the team need to have a shared goal and vision of the outcomes they hope to achieve, and also need to have an internal awareness of their differences and how to manage these. At an organisational level, there need to be formal procedures in place that facilitate collaboration by clearly describing the expectations and responsibilities of those involved, and there needs to be good governance to lead, direct and support the collaborative working.

3.4.3 Screening and Profiling the School: Needs Assessment

The RtI Teams meet regularly across the school year, and most schools in their review ran screening sessions up to three times a year to support progress monitoring. From their evidence, the implementation of the RtI model is characterised by a tailored approach for each school. This includes flexibility in moving children between each tier as their progress is noted and their needs change (O'Connor et al., 2014). This ensures each child has the right support at the right time, which mirrors the Irish perspective of a tiered model in the context of a continuum-of-support framework (Department of Education and Science, 2007; Department of Education and Skills, 2017a, 2017b, 2019a, 2019b; Inter-Departmental Group, 2015; NCSE, 2014, 2017) Having a regular process of screening contributes to the success of the model.

3.4.4 Monitoring Tiered Models of Intervention and Fidelity

Implementing the tiered model both in therapeutic and educational contexts, requires clarity on the differences between each tier for all practitioners involved, clarity on how to move between each level and a process for ensuring the model is being implemented (Murawski and Hughes, 2009). In RtI and P4C, the emphasis is on high-quality instruction, which is evidence-based at all levels. In addition, in P4C (with respect to OT) the added therapy focus also includes a specific focus on universal design for learning (Tier 1), differentiated instruction (Tier 2) and accommodation (Tier 3). For RtI, the emphasis on measuring treatment integrity is a critical aspect of implementation, to ensure the realisation of the full potential of the tiered model (Sanetti, 2015). Treatment integrity in P4C was ensured by the provision of a targeted training programme for therapists, alongside monthly mentoring, peer support, and the clear design of the tiered model as an evidence-based framework for therapy services from the outset, which was established via the initial pilot research for P4C. This meant that the varied forms of service delivery were already identified and built into the educational induction training developed by the project coordinator, and involved the employment of experts to conduct workshops and develop training materials (Pollock et al., 2017). Examples of their training programme content is described in Pollock et al. (2017) and included workshops and online modules on aspects such as introduction to the P4C model and promoting sustainable change, understanding the Canadian school system and working in the education sector, understanding the P4C model and the RtI pyramid, assessment within the P4C model, Occupational Therapy skills for each tier (mediation techniques and strategies), and promoting sustainable change through knowledge translation and coaching.

3.5 Key Ingredients for Success in Implementing a Tiered Model of Therapy Provision

Three essential ingredients have been identified for successful implementation of a tiered model of school-based therapy provision based on these models of delivery. These are (i) relationship building, (ii) knowledge translation and (iii) enhancing participation for children and youth (Missiuna et al., 2012).

3.5.1 Relationship Building

Relationship building requires regular attendance at the same school (which for many of the projects reviewed was one day a week) to ensure the therapist becomes embedded as part of the staff and school team. Both the educators and therapists require time to establish knowledge of each other's roles, the educational needs of the children and to develop insights into how to tailor the curriculum demands to the different needs of each child. In addition to the factors that promote inter-professional collaboration outlined above, there also needs to be regular dedicated time available for this collaboration (White and Spenser, 2018). Furthermore, consistent relationships with the same professionals over time mean that this relationship is built on trust and has been found to help break down professional boundaries (McKean et al., 2017).

3.5.2 Knowledge Translation

Knowledge translation requires a two-way transfer of knowledge so that each of the therapists and educators has opportunities to enhance knowledge and to ensure service delivery for each of the three tiers is tailored to the needs of the child and the school concerning educational outcomes. This requires a collaborative problem-solving approach similar to RtI. Central to knowledge translation is a focus on coaching as an approach to work together to implement a new strategy, to determine through trial and error whether it might work for the child and to problem-solve together. This was also noted by McKean et al. (2017) who found that staff appreciated and benefited from co-practice that involved observation, demonstration and feedback rather than only through programmes or advice, aligning more with coaching than consultancy to achieve behavioural change.

3.5.3 Enhancing Participation for Children and Youth

Although educational outcomes may not match specific therapy outcomes, both educator and therapist share common goals of participation and inclusion that align with the goals of children with disabilities (Gallagher et al., 2019), and this needs to be a central emphasis in the therapy service and support interventions. Ongoing research being conducted by the NBSS in Ireland highlights the critical importance of enhancing participation through eliciting students' views on the ways they need to work, skills they need to develop and changes they need to make in the context of a Tier 3 equivalent intervention (NBSS, 2014c).

3.6 Key Challenges to Implementing a Tiered Model of Therapy Provision

There are challenges in adopting this new approach from the perspective of both the educators and the therapists, as it requires practitioners to deal with a new way of working and establishing new roles. Noted barriers to implementation have included lack of time, limited knowledge of the model and limited evidence of outcomes for each tier, as well as lack of administrative and policy support(See for example Cahill et al., 2014). In adopting a tiered model, there is evidence that therapists struggle to understand how to collaborate effectively (Bose and Hinojosa, 2008).

In Occupational Therapy, this was particularly evident in P4C when the new model was being established. Therapists reported that they feel empowered to be effective in this model, as they were working on activity and participation in a natural context, where and when it occurred (Camden et al, 2015). However, it was dependent on the provision of training and mentoring of the school-based therapists, which was identified as the most significant influence on their ability to work to this model effectively. Consequently, they were provided with monthly mentoring and the opportunities to share experiences and share skills and knowledge as part of therapist capacity-building (Campbell et al., 2012; Pollock et al., 2017). Also, therapists found they needed to become enculturated into school-based practice, moving away from a medical model to one of social justice and inclusion. This was facilitated by ensuring therapists worked to develop relationships and establish trust with teachers by spending full days at schools, helping in school routines and participation in school activities, to become familiar also with daily demands that school staff face (Wilson and Harris, 2018; Simmons Carlsson et al., 2007).

Similarly, in the Speech and Language Therapy literature, the establishment of a new role in schools was identified as an issue and raised the issue of the need to expand their idea of intervention in the tiered approach. For example, it was noted that at all tiers, providing courses at a whole-school level to teachers is not effective without individual coaching and feedback tailored to the needs of staff (Ebbels et al., 2019). Tailoring interventions to the local need is, therefore, a central aspect of collaborative consultation. This requires therapists to assess local needs, and then tailor the service to respond to this need, to be able to provide the right service at the right time. Overall, evidence from both therapy disciplines shows that transitioning to new ways of working requires time and support to monitor fidelity to treatment.[37]

Some evidence about challenges from an educators' perspective has been examined. Fundamental to this new way of working was the realisation that a period of transition is required. In their longitudinal study, stakeholders in P4C identified that the transition period was a significant issue, where educators needed to learn about the new model, how it differed from traditional models and everyone's role and responsibilities within it (Missiuna et al., 2015). Educators have reported high levels of exhaustion when implementing a tiered model in the first year (see, for example, Oakes, Lane, Jenkins and Booker, 2013) (Oakes et al., 2013). However, the educators in this study also reported high levels of personal accomplishment at the same time.

37 Which includes medical model tracking, as noted in P4C whereby the risk is for therapists to revert to more typical ways of providing interventions.

In other studies where a tiered model has been well embedded, educators reported difficulties in meeting the needs of students promptly, if they do not respond to intervention at Tier 2, for example (Braun et al., 2018). However, there is also evidence of outcomes relating to educators' experiences of a new therapy service being implemented: here it was identified that educators overwhelmingly preferred this model of service delivery than the traditional clinic-based therapy provision (Wilson and Harris, 2018).

Few studies examined the effectiveness of service delivery model of governance. Still, one study from Greece identified that school-based therapy services were most effective when educators and health professionals are employed by the same management (Strogolis et al., 2011).

In summary, the tiered model for school-based therapy practice constitutes new and unfamiliar ways of working and as such, demands different skills and processes than those required within traditional individualised services.

3.7 The Tiered Model: Examining what Constitutes each Tier

As noted, in both Occupational Therapy and Speech and Language Therapy and similar to the continuum-of-support framework in the Irish context, the three-tiered approach is described as a continuum of service delivery (Ebbels et al., 2019). In this section, we have summarised the overlapping agreement on what constitutes intervention at each tier from the international literature in the following section, to synthesise the core characteristics which then serve to inform the evaluation of the Demonstration Project. However, the differentiation between tiers is less clear between studies, and there is a need to also review evidence from each therapy profession separately to determine what might influence these differences.

3.7.1 Tier 1

Tier 1 is considered a 'universal' approach and is concerned with monitoring the progress of all students. It is often deemed to be a tier that aims at the promotion of learning. Tier 1 involves improving the ability of parents and educational professionals to identify general needs in children concerning areas that impact learning and inclusion. Tier 1 interventions aim to support educators to deliver programmes that are linked to the curriculum and incorporate high-quality teaching and classroom management strategies to support the development of skills such as communication and language, and learning support skills such as handwriting, attentiveness and behaviour. This may involve, for example, working with school staff to design a whole-school curriculum on handwriting for all students (Chu, 2017). Tier 1 interventions require concerted time and effort to make an impact. For example, research by Lathouras, Westerveld and Trembath (2019) has shown that even when universal programmes show positive results immediately post-intervention, further intervention is needed for some students to maintain these effects. From the international evidence, it is clear that training alone does not result in behavioural change. Still, that ongoing support from therapists, such as individual observation sessions with coaching and/or feedback, is required.

In Occupational Therapy, the goal of Tier 1 is to embed strategies into the routines of the school day to maximise every child's ability to function, based on evidence that this provides children with more frequent exposure and practice over time, which results in more successful outcomes (Dunn, 2011). Focus on function is typically concerned with self-help, transitions, organisation, movement skills for handwriting or PE, and sensory processing (Cahill, 2010). The Occupational Therapist works with the teacher to identify ways to maximise learning in the school environment, through analysing accessibility of tools, desks and materials for example, or modifying routines to maximise inclusion of all children. In some tiered approaches, Tier 1 is titled Universal Design for Learning, which is modelled on the RtI approach. The aim is to provide supports for all children in the classroom (Chu, 2017). The objective in Tier 1 is to remove barriers that prevent successful participation that is good for all but essential for some (Mussiuna et al., 2015). Evidence is scarce on children's involvement in decision-making within the tiered approach. However, Best Practice Guidelines for School-based Occupational Therapy Practice (USA) recommends the involvement of student training equally to staff training at Tier 1: for example, an assembly on disability awareness for students (AOTA, 2008). Evidence of parental involvement in Tier 1 in Occupational Therapy literature is less prevalent than in Speech and Language Therapy and appears to be focused more on Tiers 2 and 3 (Novak, 2014).

Examples of a Tier 1 intervention for Speech and Language Therapy can involve the inclusion of a universal language curriculum or use of assessment data to guide lesson planning (Markussen-Brown et al., 2017). Studies in Speech and Language Therapy show that when educators are given discipline-specific knowledge, and individual coaching of teaching strategies, the quality of their interactions with children significantly increases (Eadie, Stark and Niklas, 2019). For Speech and Language Therapy, Tier 1 also involves coaching and training parents on how to provide increased opportunities for children to develop their communication skills in everyday interactions at school and home. The evidence of parents being involved in Tier 1 is in relation to preventative, health promotion programmes predominantly at pre-school level (Eadie, Stark and Niklas, 2019). Both therapy disciplines are consistent in viewing Tier 1 as an indirect model of intervention, where the aim is to provide universal instruction programmes and materials for educators to deliver to all children.

Table 3.2: Summary of Tier 1

- Overall aim is to support all students access the general educational curriculum to enhance participation and inclusion for all (Hutton, 2009).
- From the therapy perspective, it is typically considered a whole-school, universal, health, well-being and education promotion and prevention-oriented approach (Chu, 2017; Ebbels et al., 2019).
- Central to this approach is a commitment to whole-school interventions such as Universal Design for Learning (Missiuna et al., 2015).
- Interventions in schools involve whole-school screening, and provision of education for educators, to enhancing their understanding of developmental differences and to build on ways to enhance access to the learning opportunities for all students.
- Therapists engage in curriculum development work, where therapists can work with educators to transfer knowledge to an educational context (Cahill, 2010; Villeneuve, 2009; Markussen-Brown et al., 2017).
- Tier 1 includes provision of coaching and training for parents (Grindal et al., 2016).
- In some countries, Tier 1 interventions have evolved into universal therapy programmes, for example in pre-schools to enhance communication (Eadie, Stark and Niklas, 2019).

3.7.2 Tier 2

Tier 2 is considered to be a targeted approach for children who fail to progress at the Tier 1 level, often described as children at risk. Tier 2 is often deemed to be a preventative tier. Tier 2 interventions typically focus on small groups of children with identified needs, where the therapists and educators develop and deliver more differentiated instructional programmes for the children in the context of the natural school environment.

In Speech and Language Therapy, Tier 2 interventions are targeted at children who are at risk or who have impoverished language skills but who are considered to be able to catch up following small group interventions. Additional supports provided in Tier 2 are often characterised by explicit, intensive instruction in small groups, extra instructional time and more opportunities to practice particular skills (Gersten et al., 2008). Tier 2 interventions usually take the form of a training programme delivered to educators, who then follow a language or communication programme often derived from a manual or are coached on how to deliver the programme regularly from a therapist. The frequency of this coaching depends on the particular programme, but is usually at least weekly or fortnightly at Tier 2 (Fricke et al., 2013). If the training is less frequent than this than smaller effects are found on the language profiles of the children (Fricke et al, 2017). There are several examples of Tier 2 programmes, such as The Let's Talk Programme (Hutchinson and Clegg, 2011), Talk Boost (Lee and Pring, 2016), Early Talk Boost (ICAN Children's Communication Charity) and the Nuffield Early Language Intervention. The intensity of instruction is increased from Tier 1 to Tier 2 interventions, and this is usually operationalised by changing the type or format of instruction or the person providing the instruction.

This corresponds to the Tier 2 concept in Occupational Therapy also: it is aimed at groups of children at risk or having difficulties in performing school activities expected of them. P4C titles this the tier of differentiated instruction (Missiuna et al, 2015). For this level of intervention in P4C, health care consent from parents is required, which was not an aspect of Tier 1. This was based on the fact that if a child seems to need more individualised intervention, then formal health care processes apply and an individual file is opened for the child. Both therapy disciplines are consistent in viewing Tier 2 as an indirect model of intervention, where the aim is to provide differentiated instruction programmes and materials for educators to deliver to groups of children at risk of being excluded from the educational experiences being provided. In keeping with the RtI model, Tier 2 interventions are often delivered if the child is not responding to Tier 1 interventions.

Table 3.3: Summary of Tier 2

- Overall aim is to provide extra support to students who have not responded to Tier 1.
- Tier 2 is aimed at students at risk, who fail to progress at Tier 1.
- From the therapy perspective, Tier 2 is considered to be a targeted approach for children at risk (but who do not have a formal diagnosis).
- Central to the Tier 2 intervention approach is a focus on differentiated instruction (Missiuna et al., 2015).
- Interventions in school involve small group programmes, co-developed by therapists and educators but delivered by educators.
- Therapists work through an educational approach to collaborate with educators, to provide classroom consultation, to explore strategies for curriculum differentiation, to provide training for educators, to provide classroom support to address learning outcomes for at risk students, (enhancing skills of workforce) (Chu, 2017; Hutton, 2009).
- Tier 2 interventions may take the form of targeted small-group manualised programmes (Ebbels et al., 2019).

3.7.3 Tier 3

Tier 3 is for students with the most complex needs (usually who have a diagnosed learning disability or need an Individual Educational Plan [IEP]), who have additional needs beyond Tiers 1 and 2, and have not responded to Tier 1 and 2 interventions. At Tier 3 there is a consensus that this is closest to traditional practice for both Occupational Therapy and Speech and Language Therapy as it involves individualised contact with a child, although this may not be delivered directly by the therapist. In both therapy professions, Tier 3 continues to concentrate on collaborative working with school staff and parents. Still, there are some differences in how Tier 3 is characterised between the different models of tiered approaches internationally.

In Occupational Therapy, in the P4C, the therapist works in collaboration with the family and educator at Tier 3, to provide appropriate accommodations.

Accommodations can be delivered as interventions with a child individually, in a small group or may involve the provision of information, environmental adaptations or strategies. Central to this approach is observational assessment, which is conducted in context here to determine environmental factors that hinder or enhance learning for this child. The therapist then tries to implement strategies to change the task demands or environmental demands and monitor the child's responses. Successful strategies are then noted in the child's Individual Education Plan (IEP) so that all staff are aware of the solutions being explored. Intervention at Tier 3 differs from traditional Occupational Therapy interventions, which more commonly aim to remediate difficulties that the child experiences (for example, fine-motor problems). For school-based Occupational Therapy, Tier 3 continues to orient around collaborative consultation when working directly with the child and prioritises aiming to change the task and environment, rather than the child. This approach is proven to be as effective as working with a remedial approach in Occupational Therapy (Law et al., 2011).

In Speech and Language Therapy, typically Tier 3 addresses the needs of the child directly or indirectly: Tier 3 can involve a remedial approach, through direct Speech and Language Therapy intervention. Ebbels et al. (2019) summarise the evidence for positive effects of *direct*, individualised one-to-one intervention in Tier 3 for Speech and Language Therapy targeting expressive language and vocabulary, but that the effects are reduced for those with more pervasive difficulties and when receptive language is targeted. Also, at this level, *indirect* individualised interventions can take place and are planned and monitored by the Speech and Language Therapist but delivered by educators and/or parents. Systematic reviews of the evidence at this level for parent-delivered Speech and Language Therapy interventions suggest that it can lead to improvements in expressive language (language use) for children, including those with Intellectual Disability (ID), but less so for receptive or understanding of language. Outcomes are better when the intervention is delivered with high dose, low frequency (e.g. a high number of exposures to a language target once per week) or low frequency, high dose (e.g. a low number of exposures to a language target five times per week) (Schmitt, Justice and Logan, 2016; Justice et al., 2017), when the interventions are distributed (e.g. spread out over a month) rather than massed (e.g. intensively delivered every day in one week) (Smith-Lock et al., 2013) and when parents receive direct coaching from Speech and Language Therapists (Tosh, Arnott and Scarinci, 2017). Children benefit most where staff are well trained and supported directly by the Speech and Language Therapist (Mecrow, Beckwith and Klee, 2010; McCartney et al., 2011).

Table 3.4: Summary of Tier 3

- Overall aim is to support students with complex needs to access the educational curriculum (Hutton, 2009).
- From the therapy perspective, it is typically considered an intensive approach, working with children who have not responded to interventions at Tiers 1 or 2 (Chu, 2017; Ebbels et al., 2019).
- Central to this approach is a commitment to accommodations (Missiuna et al., 2015).
- Interventions in schools can involve individualised, or small group direct or indirect educational interventions to support inclusion.
- Designed based on contextual observations to determine environmental influences and task demands.
- No formal diagnostic assessments are involved but observational assessments used to determine possible barriers and solutions through trial and error, and collaborative consultation.
- Referral to specialist services and knowledge translation for school is also a key part of Tier 3 (Hutton, 2009).

3.8 Outcomes and Effectiveness Relevant to Demonstration Project

The primary outcome for school-based therapy is to maximise the potential for inclusion and social participation in educational settings for all children. The overarching concept of participation is central and reflects a rights-based approach, whereby all children should have equal opportunities for experience. However, in the international evidence, therapists have reported difficulties in working towards participation outcomes (Leigers, Meyers and Schneck, 2016). Instead, developmental and remedial approaches still tend to predominate (Bonnard and Anaby, 2016). Depsite the emphasis in tiered models for data-driven decision-making, occupational therapists identify that the main source of knowledge as a basis for recommendations is primarily clinical reasoning, prior experience and direct observation (72%), with best available evidence only being a source for decision-making 27% of the time (Cahill, 2010). There needs to be a broader scope of practice that focuses on social participation alongside academic learning to address more holistically the inclusion of all students. This is congruent with the NCSE foundational principles and broad, inclusive educational outcomes for all students that underpin the Demonstration Project (NCSE, 2014):

- academic achievement-related outcomes such as literacy, numeracy, examination results
- attendance-related outcomes (such as school attendance, early school leaving)
- happiness-related outcomes such as well-being, confidence, positive relationships, quality of life
- independence-related outcomes such as resilience, socialisation, mobility, assistive devices
- end of school outcomes.

The outline of evidence from examples of therapy outcomes is presented in Appendix C to support the Demonstration Project to build on its own data-driven decision-making processes.[38]

Studies that examine the effectiveness of service delivery consistently stress the need for meaningful communication and collaborative consultation for this systems model of service delivery to work. This way of working demands a thorough understanding of the roles of the school staff and the school curriculum, including in-depth knowledge of department of education directives, policy, circulars and standards.

- In P4C, this was achieved by therapists' regular weekly presence, combined with therapy engagement from the start, in weekly classroom activities in each school, to spend time in the classroom and gain insight into the school culture, classroom routines and activities, alongside educators' different styles and curriculum demands.
- Similarly, in a review of a school-commission model of Speech and Language Therapy in the UK, it was noted that regular dedicated time is required for collaboration and that a consistent relationship with the same professional overtime was an important aspect of building trust and enabling co-practice across professional boundaries (McKean et al., 2017).
- In a critical review of the evidence of effective implementation of collaborative consultation, Villeneuve found two key inter-related factors that impacted negatively: (i) the inconsistent presence of therapists in schools and (ii) insufficient time to collaborate (Villeneuve, 2009).

Studies such as this informed the design of the P4C programme, which went on to deliver school-based therapy every week to each school. Similarly, a UK-based study found that in order to establish successful collaboration and co-practice amongst practitioners, strong relationships built on trust and mutual understanding are required, and key to this was having regular accessibility to each other in order to respond in a timely manner (McKean et al., 2017). A recent Irish study of Speech and Language Therapy services in a school also stated that weekly liaison with teachers was an essential ingredient to successful service delivery, as it proved to be an extremely important factor in identifying children having difficulties and reinforcing therapy programmes (O'Connor et al., 2012). While the evidence on frequency is not definitive, another Canadian study demonstrated that 'irregular' visits across the school year are not as effective as 'frequent', intense visits which are recommended in situations where the service delivery is not based on weekly attendance on-site (Bayona et al, 2006). This is because, in services where it is not possible for the therapist to be on-site on a regular basis, the service delivery model tends to revert to more traditional approaches of therapy provision resulting in an approach that relies on referrals, and is not collaborative or capacity building in focus.

38 Note: In studies of tiered models, school-based therapists are typically based regularly in each school, and evidence of effectiveness is based on service delivery that is usually provided on a weekly basis across the school year, in terms of frequency.

3.9 Conclusion

Overall, from the review of evidence, there is as yet a lack of clarity in what a multi-disciplinary school-based therapy practice is and should be. Further work needs to be done to synthesise inter-professional best practice principles to guide new programmes such as the Demonstration Project (Anaby et al., 2016). Education contexts differ internationally, and acknowledging and understanding these contexts is central to how effective multi-disciplinary school-based therapy practice will be. While acknowledging differences across education contexts internationally, there is much we can learn from international school-based therapy practices. In particular, evidence of what works, what the barriers are and most importantly what the emerging key principles are for effective service delivery models and subsequent knowledge and skill-base needed by the therapists and educators who will work there. Therefore, from this review of international evidence alongside the analysis of Irish tiered models in Section 2, some benchmarks can be determined with which to evaluate this Demonstration Project. Furthermore, the Demonstration Project is underpinned by a clear position and commitment to a tiered model of support (NCSE, 2017). According to this report, successful implementation requires a key element: '*embedding of a continuum-of-support framework into schools' policies and practices*' (p. 9).

Overall Model of Implementation: When these elements are combined, it can be recommended that the new school-based therapy model encompasses core essential elements:

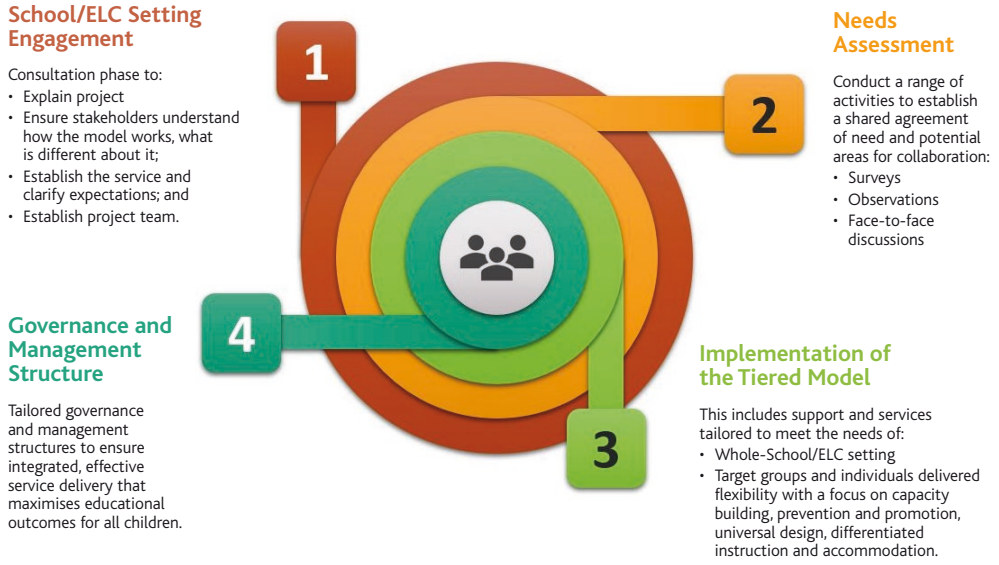
a) school engagement to ensure shared understanding and to establish a project team

b) needs assessment to determine potential areas of concern relating to educational outcomes

c) tiered model of service provision that is embedded in the existing educational context

d) a tailored governance and management structure to ensure fidelity in implementation (see figure 3.1).

Figure 3.1: An Integrated Model of School-Based Therapy



Source: Evaluation Team

Characterised by a clearly articulated tiered model: As noted in the literature review, the tiers are typically described in relation to the characteristics of the child (e.g. their learning needs, such as education for all, for those at risk, for those with identified special needs), and in relation to the type of service or intervention (e.g. universal, targeted or intensive). Combining these perspectives helps clarify differences between tiers and establish shared understanding (see Table 3.5). These identified factors are complex and take time to develop in any school or early educational setting, but are essential for the long-term success of the Demonstration Project.

Table 3.5: Describing the Tiered Approach as an Integrated Model of Therapy Practice

Tier	Characteristics of the child	Type of intervention	Relationship to educational need	Focus of delivery
Tier 1	Education for all	Universal design for learning	General curriculum	Collaborative consultation, coaching, capacity-building, shared problem-solving and delivery of interventions
Tier 2	For those at risk	Targeted	Differentiated curriculum	
Tier 3	For those with identified special needs	Intensive	Accommodation or individual education-oriented interventions	

4. Methodology

4.1 Introduction

The methodological approach adopted for this project was concerned with selecting a framework focused on answering practical, applied, real-world questions concerning the impact of the Demonstration Project from a policy and practice perspective. A methodical review of the literature was conducted and continued to inform the methodological approach in an iterative manner throughout the evaluation process. A multi-method ecological evaluation framework, underpinned by a methodical literature review, was therefore developed, which combined both qualitative and quantitative measures (Dahler-Larsen, 2018). In this chapter, the multi-method ecological evaluation framework is presented, evaluation methods described, access, sampling decisions and data analysis explained, trustworthiness interrogated and the limitations of the research articulated.

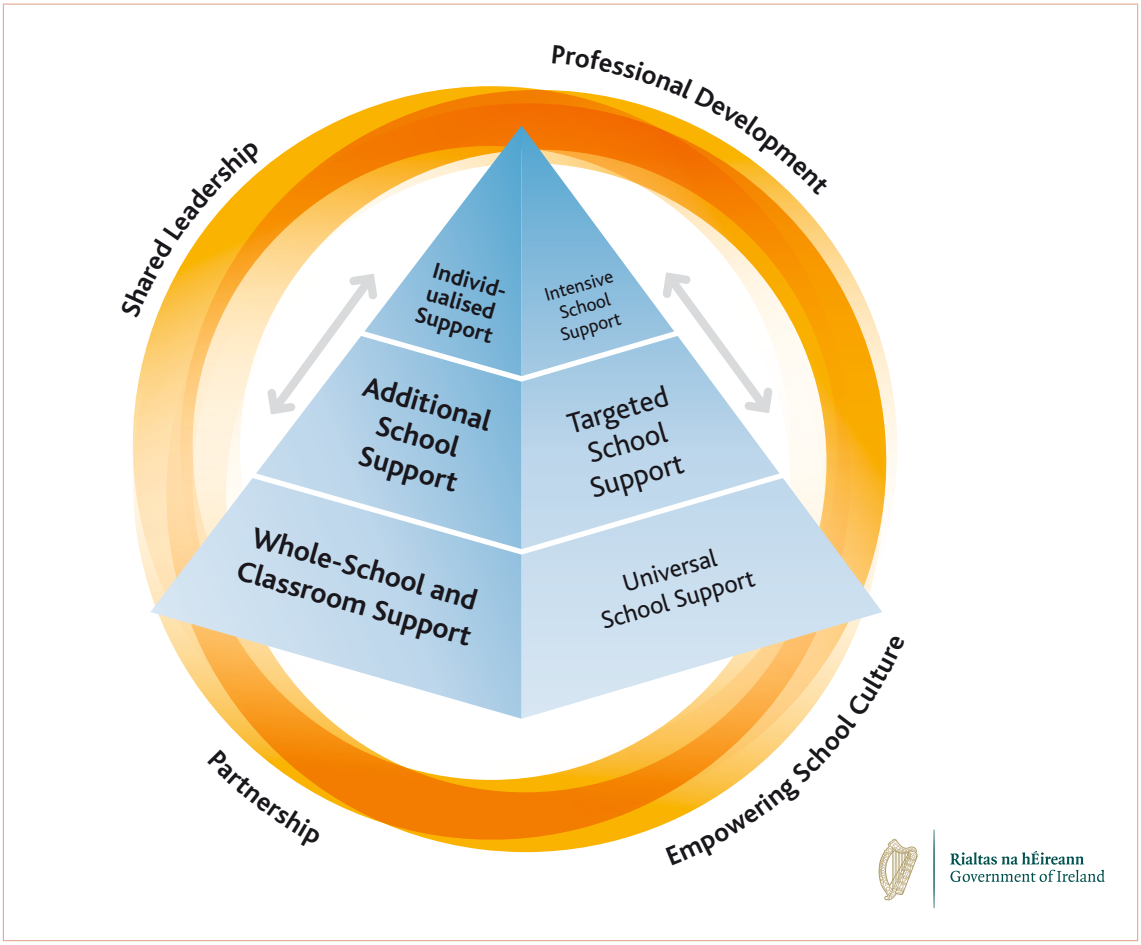
4.2 A Multi-Method Ecological Evaluation Framework

Underpinning the multi-method ecological framework adopted for this research was the concept explored previously in the literature review, of a system's approach to inclusion which is designed to provide a continuum of support within schools, and between specific school settings from full inclusion in mainstream classes to dedicated provision in special schools (Department of Education and Skills, 2017a). This concept is further mirrored in the ELC system where the Access and Inclusion Model (AIM) also promotes the concept of a continuum of support across the seven levels of the model (Inter-Departmental Group, 2015).

An ecological approach was adopted to capture the complexity of inclusion and the multiple contextual dimensions contributing to effective inclusive education systems suggested by the literature (NCSE, 2011). The concept of a methodological ecological approach can be traced to the work of Bronfenbrenner (1979). Bronfenbrenner (1979) suggested moving away from the then predominant theoretical model focusing exclusively on the child, and instead suggested that all relationships in each child's ecosystem impact on the child's learning and development and should therefore be considered in the context of an education system to enable each child to achieve his/her potential. The approach was recently affirmed by research commissioned by the National Council for Curriculum and Assessment (NCCA) focused on exploring research-informed theoretical approaches for children's learning and development (Ring et al., 2018). This approach aligns with the interactionist/ecological perspective as advocated by the biopsychosocial model (Desforges and Lindsay, 2010), whereby both within-child factors and the broad range of environmental factors impacting on each child are considered in planning for children's learning in schools. Viewing educational provision for children with special educational needs in this way enables special education provision to enhance the support factors and reduce the impact of stress factors and other barriers to learning, thus enhancing children's participation and achievement in education (Desforges and Lindsay, 2010).

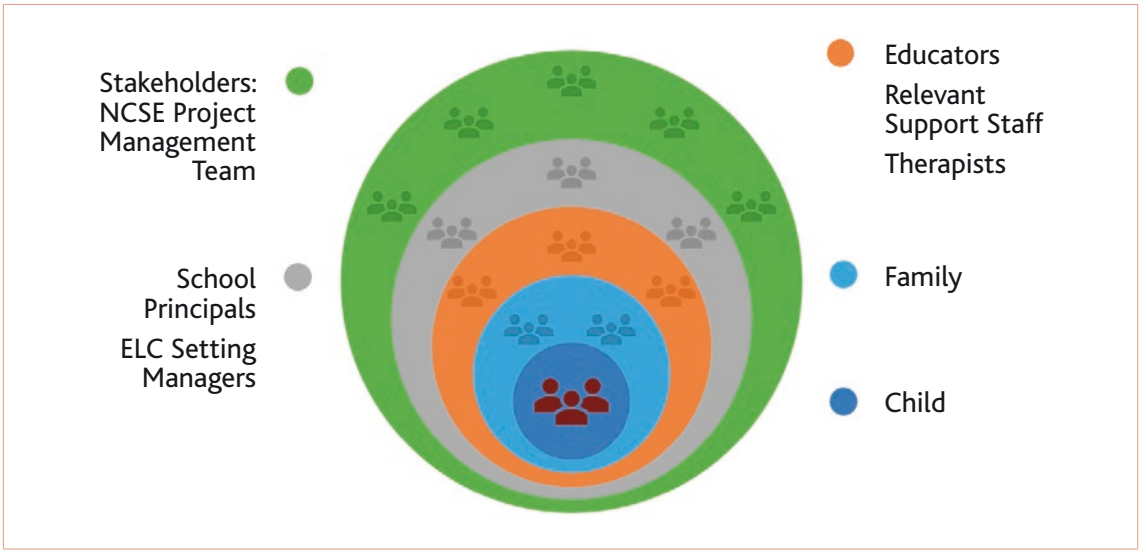
Within this context as described in the literature review, a tiered approach to therapy provision in schools has the potential to support inclusion and maximise the use of resources (Camden et al., 2015). In essence, therefore, the evaluation framework adopted was designed to capture the impact of the Demonstration Project from an interactionist/ecological perspective as advocated by the biopsychosocial model through engaging with the multiple influences on the child's learning and development associated with participating in the Demonstration Project. This approach aligned with the aim of the research in assessing and identifying the impact of the Demonstration Project. Multiple methods therefore, combining both qualitative and quantitative approaches, were designed and adopted to capture the impact of the Demonstration Project through the lens of the continuum-of-support model developed by the NCSE at figure 4.1 below, on the child, family and educators.

Figure 4.1: Multi-Tiered Continuum of Support



The multi-method ecological evaluation framework was designed specifically to capture the effectiveness of the Demonstration Project in the context of implementing a whole-setting, targeted and intensive approach that is responsive to the child's developmental abilities and needs, acknowledges the multiple influences on the child, while simultaneously promoting inclusion. Data sources reflect the ecological, interactionist/biopsychosocial foci of the model and were collected across the range of contexts in the ecosystem detailed in Figure 4.2 below.

Figure 4.2: Ecological Contexts for Collection of Data



Within these data contexts, a range of methods was utilised comprising documentary analysis, online questionnaires, World Café (group interviewing), semi-structured face-to-face/telephone interviews, and drawing and telling (Johnson, and Christensen, 2017). World Café, semi-structured face-to-face/telephone interviews and drawing and telling were conducted with stakeholders, therapists and in 20 selected case study sites. These approaches are described in detail below. The case study approach adopted encompasses the exploratory, explanatory and descriptive dimensions suggested by Yin (2014) and were not considered mutually exclusive dimensions in reporting the research findings. In the context of this research, a case study was considered as a research strategy comprising an empirical investigation designed to observe effects in real contexts, and thereby acknowledging the relationship between context and research outcomes (Cohen, Manion and Morrison, 2017). The 20 case study sites were selected on a proportionate basis from the 150 sites participating in the Demonstration Project and comprised 8 ELC settings, 7 primary schools, 3 post-primary schools and 2 special schools. In terms of each case study site, tracker data and chart analysis were conducted, managers/principals, staff and parents were invited to participate in interviews, staff and therapists were invited to World Café sessions and children were invited to engage with the researchers through a drawing and telling approach. These data are quantified in the relevant subsequent sections of this report.

4.3 Literature Review

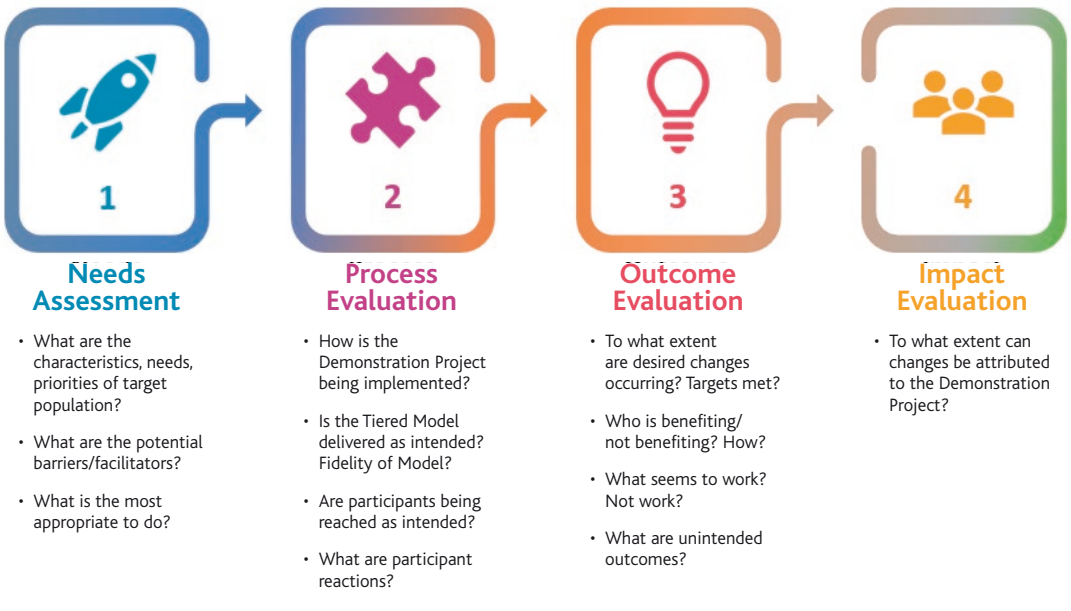
As noted in section 3, a methodical review of the literature, comprising both an empirical and an expert strand, was conducted in order to provide a robust, empirically based context for the research and to identify models of best practice in relation to the provision of therapy in tiered models in educational contexts (Bond et al, 2013). This review continued to inform the methodological approach in an iterative manner throughout the evaluation process. The empirical strand included a focused search of electronic databases and web searches to locate peer-reviewed studies, while the expert strand focused on locating reports, reviews and articles based on expert/professional opinion and experience.

Peer-reviewed publications published in English between 1990 and 2018 were identified through electronic databases: PsycINFO; Science Direct; Scopus; ERIC and ProQuest. Web searches were also undertaken using Google Scholar, Education-line and OECD Education at a Glance. Where, during searches, literature pre-1990 emerged and was deemed to be significant, taking into consideration the focus of the project, this literature was reviewed. Expert reports, reviews and articles based on expert/professional opinion published in English between 1990 and 2018 were also included. Web searches were undertaken using Google, Google Scholar and Education-line. Similar to the approach adopted in relation to the empirical strand, where literature pre-1990 emerged was deemed to be significant, this literature was reviewed. Prior to engaging in the literature search, search terms were developed based on the considerable knowledge and expertise of the team and the team's engagement with the literature. The data extracted from the literature review was synthesised in the themes as reported in the literature review.

4.4 Evaluation Methods

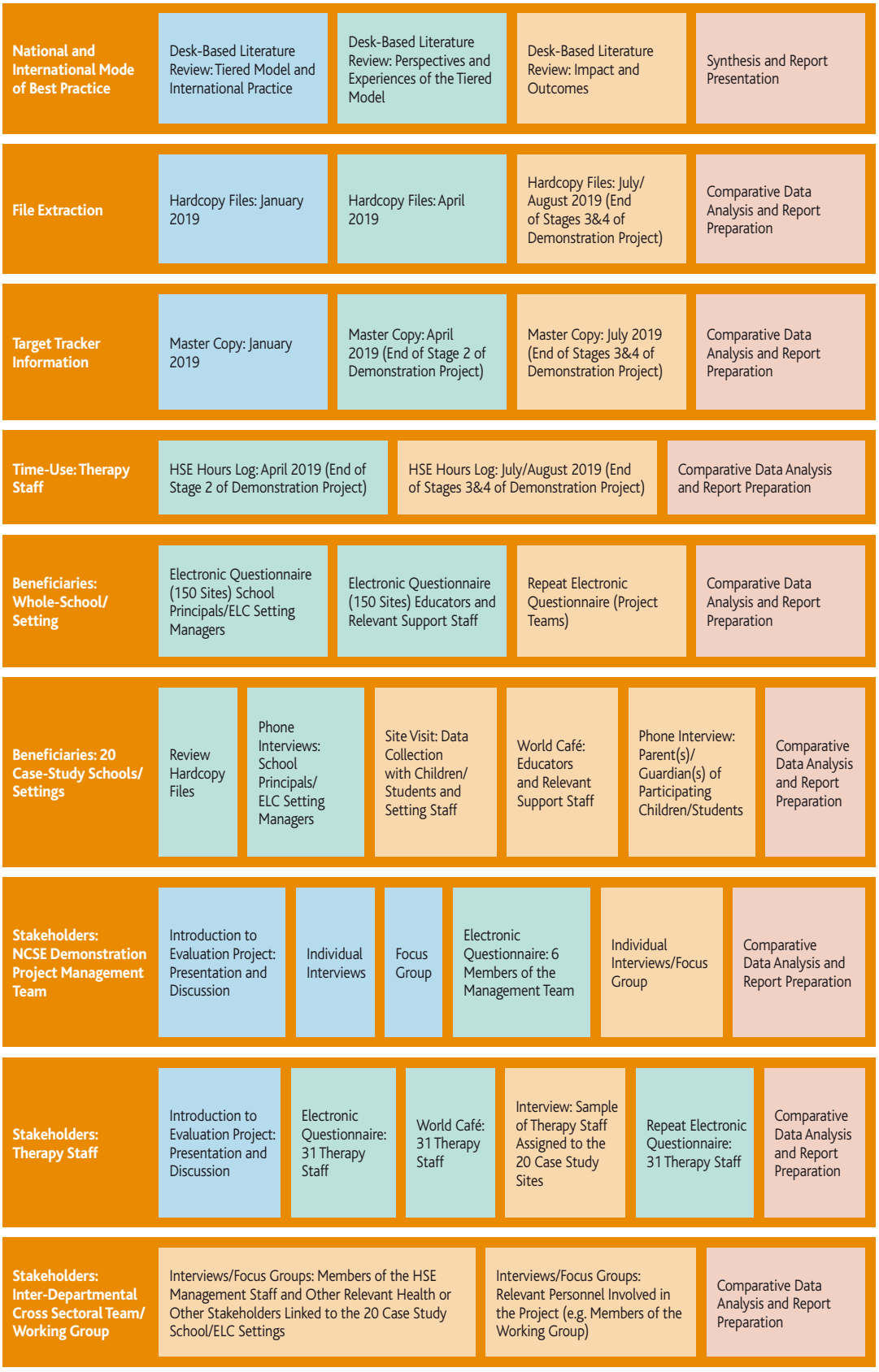
The evaluation methods adopted emerged from the four key analysis domains summarised in Figure 4.3 below, related to Needs Assessment, Process Evaluation, Outcome Evaluation and Impact Evaluation.

Figure 4.3: Evaluation Methodology: Analysis Domains



Combined, the overall approach to data collection warranted an evolving process of data collection across time, space and people and is summarised in Figure 4.4 below. The colours indicate the sequential time-line from blue, green, yellow and to the final stage in pink across all data collection points.

Figure 4.4: Overview of Data Collection and Analysis



4.4.1 Documentary Analysis

During the initial start-up phase of the Demonstration Project, a centralised 'Target Tracker' document was compiled, which mapped the targets (goals) being set for the participating schools and ELC settings. This 'Target Tracker' was developed by both Clinical Leads, utilised a mainstream spreadsheet application and was built as a linear, multi-data entry system using Microsoft Excel.™ The 'Target Tracker' was designed to be a readily available and easy to use spreadsheet platform that provided the opportunity to display text and numerical data sets using graphing sets, while also allowing for some manipulation of data and inter-data calculations in order to easily track the Demonstration Project's achievements. It was imperative therefore that the 'Target Tracker' was examined in relation to the 150 sites participating in the Demonstration Project and that an intensive analysis of this data was conducted for the 20 case study sites. The number of targets examined across all settings and specific to individual tiers are detailed in Table 4.1 below.

Table 4.1: Target Tracker Examination Across All Settings and Tiers

Evaluation method	Overview	Time-Frame
Target Tracker	Review of master copy of Target Tracker and tiers at which targets were set across ELC settings and schools	January 2019
	Review of updated master copy of Target Tracker and tiers at which targets were set across ELC settings and schools	March 2019
	Review of updated master copy of Target Tracker and tiers at which targets were set across ELC settings and schools	April 2019
	Review of final master copy of Target Tracker and tiers at which targets were set across ELC settings and schools	July 2019
Hard-copy file extraction	37 hard-copy files (20 case study settings)	January 2019
	37 hard-copy files (20 case study settings)	April 2019
	37 hard-copy files (20 case study settings)	July 2019

A repeat audit approach to the evaluation of the 'Target Tracker' process was adopted focused on management arrangements, target setting and an in-depth review of a sample of hard-copy files. This repeat audit approach was conducted over four consecutive timeframes – January, March, April and July 2019.

An overview of the range of documentation examined is included in Appendix D. Analysis was conducted with reference to the fidelity of the implementation of the tiered model and the associated elements of assessment of need, capacity-building, prevention, universal design for learning (UDL), differentiation in implementation and accommodation. Individual tiers were conceptualised within an integrated model of therapy practice combined with the continuum-of-support framework in place in schools and in the AIM in ELC settings (Inter-Departmental Group, 2015). Specific attention was also directed to governance and management structures in analysing the documentation that was made available. This analysis adopted the thematic approach detailed in Table 4.5 below.

4.4.2 Online Questionnaires

Online questionnaires were selected based on their efficiency as a method to collect data and capture participants' attitudes, beliefs, opinions, values and experiences of the Demonstration Project, in addition to providing relevant demographic and background information (Johnson and Christensen, 2017). The SurveyMonkey platform was used to host the online questionnaires. Table 4.2 below provides details of the online questionnaires utilised in the evaluation. An online format was deemed appropriate as the research team had access to all settings involved in the project and were thus able to ensure that all settings were aware of and had access to the online format. An example of the online questionnaire is provided in Appendix E.

Table 4.2: Overview of Online Questionnaires

Evaluation Method	Overview	Time-Frame
Online Questionnaire	Therapists Project Scoping Questionnaire (n=24)	March 2019
	Principals/Managers/Scoping Questionnaires (n=87)	February-March 2019
	Educators/Relevant Support Staff Scoping Questionnaires (n=212)	February-March 2019
	NCSE Project Management Team Project Questionnaires (n=5)	January-March 2019
	Therapists Post-Project Questionnaire (n=27)	July 2019
	Project Team (Setting representatives) Post-Project Questionnaire (n=83)	May-June 2019

4.4.3 World Café

The World Café method is based on seven key design principles focused on inviting participants that can contribute meaningfully to the conversation: context; creating hospitable spaces; exploring relevant questions; supporting and facilitating each participant's contribution; connecting diverse perspectives; engaging in shared listening; and sharing collective discoveries (Brown and Isaacs, 2005). In designing the questions for the two world cafés, summarised in Table 4.3 below, attention was directed to the seven key design principles and cultivating collaborative dialogue. Copies of the questions used for the World Café process are available in Appendix F.

Table 4.3: Overview of World Cafés

Evaluation Method	Overview	Time-Frame
World Café	Therapists (n=31)	March 2019
	Principals/Managers/Educators/Relevant Support Staff (n=16)	May 2019

Participants moved between tables during the therapists' sessions. However, due to the small numbers attending the educators' session it was deemed more appropriate for participants to remain at their tables rather than move between tables. The researchers remained alert to the most effective use of questions and the importance of connecting and cross-pollinating ideas to enrich the data emerging from the process (The World Café Community Foundation, 2015). Data were recorded by members of the research team through handwritten note-taking. This enabled the researcher to continually check participants' contribution to the discussion as the process involved. These handwritten records were typed and uploaded as Microsoft Word documents for subsequent analysis.

4.4.4 Semi-Structured Interviews

Semi-structured interviews were selected to allow the researchers to adopt a flexible approach in probing participants' perspectives and understanding (Merriam and Tisdall, 2007). Principles/managers (n=20), educators (n=55), parents (n=26), NCSE working group (n=15) and NCSE project management (n= 6) participated in individual, semi-structured interviews. Both face-to-face and telephone interviews were conducted. See Appendix G for copies of sample interview transcripts. Information related to the interview schedules is included in Appendix H.

4.4.5 Drawing and Telling

Article 12 of The United Nations (UN) Convention on the Rights of the Child (1989) expressly states that children have the right to have their opinions considered and their views respected in decision-making that affects them. This principle of consulting with and responding to children is further reinforced in *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020* (DCYA, 2014). In accordance with these principles and a belief in the importance of listening to children, children were invited to engage in child conferences and draw a picture of how they experienced the project in their respective education settings (Clark and Moss, 2011). Questions were differentiated for younger and older children and adapted during the child conferences in response to children's individual abilities. In order to provide motivating participatory contexts for children (White et al., 2016), a wide range of attractive drawing implements were provided and children were invited to select the colour and size of the paper they wished to draw on. The drawing was then used as a stimulus for discussion in relation to children's experience.

4.5 Access and Sampling

The research team had access to all participants involved in the Demonstration Project and was therefore in a position to invite and include all relevant stakeholders and settings in the evaluation process. Access to parents and children were sought through the relevant education setting. Ethical approval for this research was secured from the Social Research Ethics Committee (SREC), University College Cork. Reflecting the iterative design of the methodology adopted, ethical applications were submitted to SREC at three different points during the research process. Specific attention was directed towards providing participants with comprehensive information

in relation to the research. The voluntary nature of participation was adhered to as a principle of ethical good practice, and participants were advised that they could withdraw consent/assent to participate at any time and without any attendant consequences. Participants were assured of confidentiality and rigorous adherence to data storage and retention protocols. *Guidance for Developing Ethical Research Projects Involving Children* (DCYA) 2012) underpinned the inclusion of children in the research and all researchers on the project engaging in fieldwork were recently Garda-vetted. See Appendix H for information letters and consent/assent forms.

4.6 Data Analysis

Data analysis was focused on the analysis of four specific domains: Needs Assessment; Process Evaluation; Outcome Evaluation and Impact Evaluation summarised previously in Figure 4.3 above. A wide range of data was collected for this project and is summarised in Table 4.4 below.

Table 4.4: Overview of Data Sources

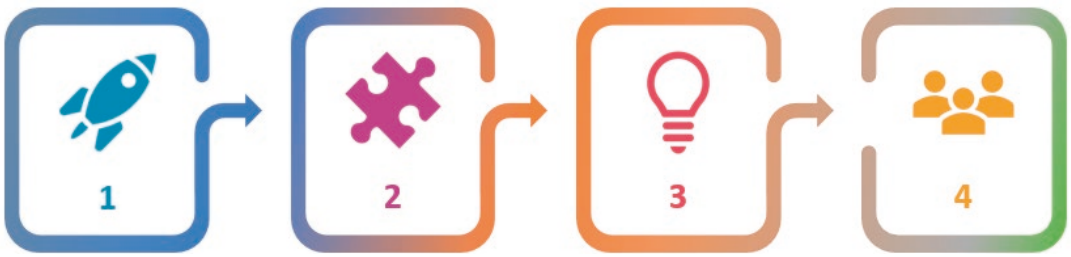
Evaluation Method	Overview	Total Data Sources for Analysis
Documentary Analysis x 3 different times (Jan, April, July)[39]	Target Tracker for 150 participating schools/ELC settings (4 iterations of tracker analysis)	1
	File Extraction (Data spot-check)	37
	File Extraction (20 Case Study Settings)	20
Project documentation materials	Folders relating to project resources provided to evaluation team	11
	Minutes of project meetings, and reports to team	25
	Other materials such as leaflets, templates, feedback forms	N/A
Online Questionnaire	Scoping Questionnaire: therapists	24
	Scoping Questionnaire: Principals/Managers	87
	Scoping Questionnaire: Educators	212
	Scoping Questionnaire: NCSE Project Management Team	5
	Post-Project Questionnaire: Therapists	27
	Post-Project Questionnaire: Project Team (Setting representatives)	83
World Cafés	Therapists World Café	27
	Principals/Managers/Educators/Relevant Support Staff	16

39 Except for the tracker data which was analysed on four different times: Jan, March, April and July).

Evaluation Method	Overview	Total Data Sources for Analysis
Semi-Structured Interviews	Telephone Interviews with Principals/Managers in 20 Case Study Settings	20
	Face-to-face interviews with Project Management Team	3
	Focus-group Interviews with Staff in 20 Case Study Settings	55
	Face-to-Face Interviews with Principals/Managers/Project Team in 20 Case Study Settings	20
	Telephone Interviews with Parents in 20 Case Study Settings	26
	Telephone/face-to-face interviews: Working Group	15
Drawing and Telling	Child conversations in 20 Case Study Settings	77

Data were analysed using the framework suggested by Braun and Clarke (2006) and applied to the four specific domains: Needs Assessment; Process Evaluation; Outcome Evaluation and Impact Evaluation. In interrogating the data, therefore, the key questions in Table 4.5 were used by the researchers to support theoretical flexibility and the organic process of coding and theme development within the qualitative paradigm to capture the complexity of the research contexts within this analytic framework thematic analysis was employed to interrogate the data and question the implications arising across these four specific domains (Clark and Braun, 2017).

Table 4.5: Data Analysis



Needs Assessment

- What are the characteristics, needs, priorities of target population?
- What are the potential barriers/facilitators?
- What is the most appropriate to do?

Process Evaluation

- How is the Demonstration Project being implemented?
- Is the Tiered Model delivered as intended? Fidelity of Model?
- Are participants being reached as intended?
- What are participant reactions?

Outcome Evaluation

- To what extent are desired changes occurring? Targets met?
- Who is benefiting/ not benefiting? How?
- What seems to work? Not work?
- What are unintended outcomes?

Impact Evaluation

- To what extent can changes be attributed to the Demonstration Project?

Analytical Process	Application to Data Corpus
Data Organisation	All Data were collated in a central repository and accessible to all of the research team, enabling all team members to engage in an iterative data analytic process.
Code Generation	Phase 1 – Data were coded systematically with reference to the four specific domains of Needs Assessment; Process Evaluation; Outcome Evaluation and Impact Evaluation.
Theme Identification	Phase 2 – All team members were assigned specific data to identify and report on themes evident in it with reference to the four specific domains of Needs Assessment; Process Evaluation; Outcome Evaluation and Impact Evaluation.
Finalising of Themes	Phase 3 – Following identification of codes, the research team engaged in a dialogic process to identify and agree the identification of the themes evident in the data. This process was conducted through four day-long meetings dedicated to the agreement of themes with the express proviso that themes were supported by robust data located in the data repository.
Reporting	Phase 4 – An agreed format to reporting the research findings was identified and a paired-process to reporting each section was put in place to provide for inter-reporting reliability with reference to the themes previously identified. In this context also, the percentage of inter-reporting agreement was calculated for each section, through calculating the percentage of incidences in which both the primary reporter and secondary researcher for each section agreed across the themes reported. High levels of inter-reporter agreement were recorded with an average agreement rate of 95% across all data sets.

In reporting the research findings, a quantitative recording process detailed in Table 4.6 below was adopted.

Table 4.6: Quantification Equivalencies Reporting Research Findings

A few		Some	Half	A Majority	Almost All	All
Up to...	20%	40%	50%	60%	80%	100%

4.7 Trustworthiness

From the initial conceptual phase of the research and throughout the process, specific attention was directed to the concept of trustworthiness as it applies to the validity and reliability of the research process (Merriam, 2009). The positivist criteria of internal and external validity, reliability and objectivity were applied to the quantitative data and the criteria of credibility, trustworthiness, dependability and confirmability applied to the qualitative data (Lincoln and Guba, 1995). Table 4.7 below provides a summary of the specific methods adopted to support the trustworthiness of the research process.

Table 4.7: Specific Methods Adopted to Support the Trustworthiness of the Research Process

Internal Validity and Credibility	• Triangulation of data sources and collection method • Use of extracts from the data in reporting findings • Consistent reflection on, and attention to the potential of researcher-effect
External Validity and Transferability	• Attention to providing rich descriptions of research contexts and process of data collection and analysis
Reliability and Dependability	• A wide variety of methods adopted to provide for methodological triangulation
Objectivity and Confirmability	• The application of all of the above elements in a systematic and transparent manner • A commitment of the research team to consistently engage in professional dialogue in a self-critical manner

4.8 Limitations

While the researchers directed attention to rigorously employing the research methods adopted throughout data collection and data analysis processes, the findings are compromised by a number of limitations, which require consideration in interpreting both the research findings and future implications identified in this report. The limitations were generated by the timescale of the study and the associated need for methodological expediency. The delay in the commencement of the project also represents a limitation in terms of the application of the findings to the school year. Both the number of sites involved in the Demonstration Project and the sample size of 20 sites compromise the potential generalisability of the findings. The heterogeneous needs of children with SEN is a further limitation in terms of generalising research findings across all contexts as the responses of research participants may be specific to the particular needs of individual children. Finally, as all of the sites involved in this phase of the project volunteered to participate, these sites may have particularly high levels of motivation rather than reflecting the spectrum of education settings more generally. All qualitative research is limited by the researcher who is, in effect, the data collection instrument, and while all of the research team are experienced researchers, the potential for bias in this phase of the research cannot be discounted. However, the research team remained conscious of and alert to their potential effect on the process, cultivated a tolerance for ambiguity and displayed sensitivity to the research context and variables (Merriam 2009). Team meetings and the collaborative nature of the project provided opportunities for individual team members to interrogate their own and others' perspectives through the lens of the empirical evidence generated by the data analysis process.

4.9 Summary

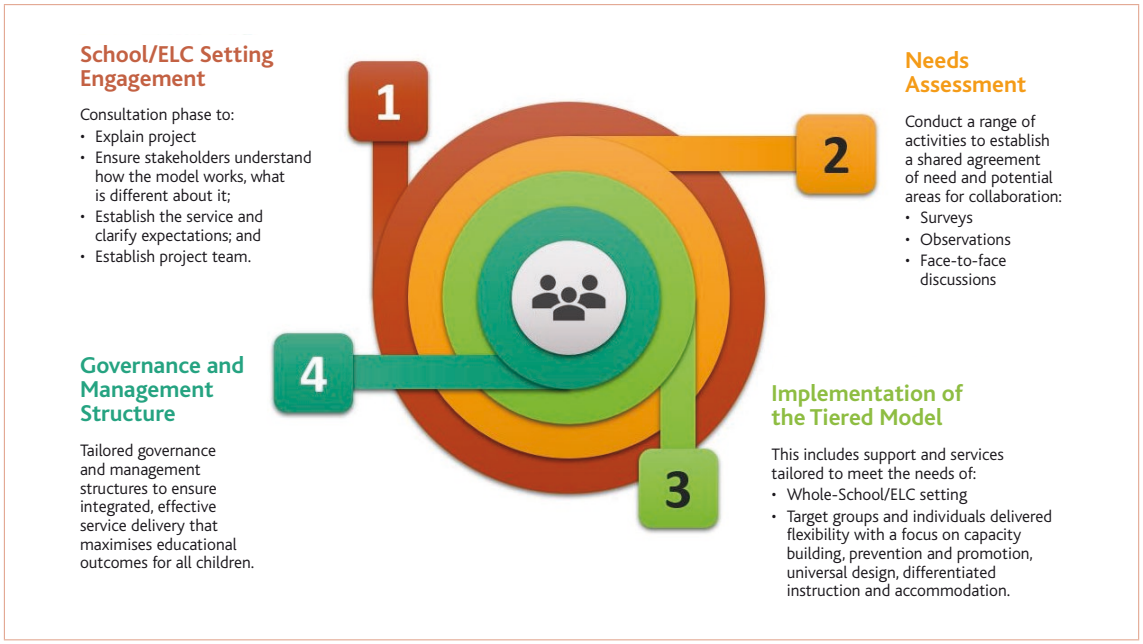
As noted previously, the multi-method ecological evaluation framework adopted for this project was concerned with selecting a framework focused on answering practical, applied, real-world questions concerning the impact of the Demonstration Project from a policy and practice perspective. Notwithstanding the specific methods adopted to support the trustworthiness of the research process summarised above, there are inevitable limitations associated with the research detailed above. However, the findings reported in the following chapters constitute a valuable repository in terms of capturing data from the four key analysis domains of Needs Assessment; Process Evaluation; Outcome Evaluation and Impact Evaluation. Critically these findings suggest future directions for policy and practice in relation to the further development of the Demonstration Project.

5. Implementation Findings

5.1 Introduction

In this section of the report, a summary of the key findings of the research is presented with reference to the development, testing and implementation of a new tiered model of in-school therapy provision as a core concern, identifying what was achieved. As noted in the summary of the literature review, the evaluation methods that were adopted emerged from a review of the project aims and purpose, alongside a review of current tiered models in Ireland alongside a synthesis of good practice. This led to the identification of a general model summarised in Figure 5.1 below related to 1) School Engagement, 2) Assessment of Need, 3) Implementation of the tiered model of therapy provision, in the context of 4) a tailored governance and management structure making specific reference to key actions such as recruitment, staff induction and engagement with key beneficiaries. In addition, the synthesis of core characteristics outlined in the literature review of evidence in Section 3 serve as a benchmark for comparing and contrasting the understanding of the model (see Table 3.4 from Section 3). Fidelity to the tiered model is addressed while impact evaluation will be targeted in Section 6. The findings are summarised and then discussed in relation to what worked well (successes), challenges, issues and implications for future practice.

Figure 5.1: An Integrated Model of School-Based Therapy[40]



40 Source: Evaluation Team.

By the end of June 2019, the Demonstration Project was fully implemented, which was evidenced by all settings being involved in the new model of therapy provision. Full implementation involved the delivery of the multi-tiered model of therapy provision, with evidence of each tier being deployed in many of the educational settings depending on a range of factors including priorities for the educational setting, capacity of the therapists to provide input and the educational settings' capacity to engage with the project. From this perspective, the tiered model was being provided in a flexible way. There was also evidence that all 150 educational settings had engagement from the Demonstration Project therapy team to varying degrees in relation to capacity, ability to engage and having needs assessed. The evaluation team found evidence of the following:

- completion of a needs appraisal at the majority of participant settings
- almost all respondents in the educators' survey (n=68) reported that the needs assessment informed the targets set for their setting, which is evidence of a tailored approach
- a multi-tiered continuum of service delivery established in all participating settings
- provision of Tier 1 interventions across all participating schools and ELC settings
- over 1,500 target interventions identified for the total sample of 150 settings
- over 67% (n=1,141) of identified targets fully completed before the end June 2019
- commencement of Tier 2 and Tier 3 interventions in a subset of the participating settings
- provision of group and individual capacity building CPD (n=265) for educational staff at the majority of participating settings
- 123 Whole-class initiatives (Tier 1) delivered during the school year
- 169 Specific coaching and classroom modelling (Tier 2) provided to teachers and early years educators
- 143 Targeted parental engagement interventions identified (Tier 2 and Tier 3)
- 167 individualised therapy support interventions (Tier 3) provided to children in participant settings.

The scale of the project in terms of time available and the proposed scoped of work (highlighted elsewhere in this report) impacted the team's capacity to implement the model in its entirety. Consequently, a choice was made to phase in the tiers during the year, with Tier 1 being the priority for the first half of the school year. The outcome was a model that was still in the early stages of being implemented, and a model that was being implemented in a generic way rather than tailored according to need. The following sections present the detailed findings relating to the process of implementing a new model of therapy provision, alongside fidelity to the model according to its vision, aims and purpose.

5.2 Recruitment and Employment Framework

5.2.1 Key Project Successes

1. Interim recruitment model agreed between NCSE and HSE to support the rapid recruitment of 31 SLTs and OTs
2. The Demonstration Project was successful in recruiting both SLTs and OTs in a short period of time
3. The Demonstration Project demonstrated the ability to recruit an experienced cohort of therapy staff (average years of experience 9.3 years)
4. Achieving relatively quick recruitment in a short space of time

5.2.2 Summary of Findings

As noted in the introduction, the Working Group for this Demonstration Project was responsible for the development of a recruitment framework to support the employment of therapy staff in an efficient manner. To devise the bespoke recruitment framework, the Working Group examined the existing mechanism for the employment of therapy staff including the centralised, national recruitment process (panel system) operated by the HSE in Ireland.[41] The HSE agreed to recruit/assign up to 31 therapy posts (19 Speech and Language Therapy posts and 12 Occupational Therapy posts) to work on the Demonstration Project. In addition, the assignment of two HSE therapy managers to the project was agreed (Demonstration Project Working Group, 2018), with the establishment of a Memorandum of Understanding setting out the agreed arrangements in place to provide for reimbursement of salaries and costs for the personnel assigned to the project and for the provision of non-pay costs associated with the project (Demonstration Project Working Group, 2018). The HSE committed to recruit to and backfill these posts from CHO 7 or other areas in order to ensure that the in-school therapy project was not displacing existing services (Demonstration Project Working Group, 2018). The recruitment of therapy staff for the Demonstration Project commenced in April/May 2018.[42] The processes put in place ensured that the project was reasonably staffed in a short period with a cohort of experienced therapists, the majority of which had over three years of experience working in children's services. Interviews and focus groups with therapy staff and with the management team identified some limitations however, which were also confirmed by consultation with the project Working Group including:

a) not being able to recruit personnel that would constitute a good match with the project
b) participating in a process of non-targeted recruitment whereby non-interested personnel would be recruited, subsequently impacting staff retention
c) delaying the recruitment of therapy staff during the early stages of the project

41 https://www.hse.ie/eng/staff/jobs/recruitment-process/how-to-apply.html.

42 Information received from focus group with NCSE management team, January 2019.

d) delays in backfilling vacant posts

e) delays in implementing an inter-disciplinary model due to lack of therapy team members in posts.

Therapists were allocated to settings based on their wish to experience the range of settings from ELC through post-primary settings, resulting in all therapists having a mixed workload across the four setting types. Senior grade staff were allocated to complex sites such as special schools as they were considered to have a more specialised skill mix and experience level. While the goal was to ensure equity across therapists in terms of workload, the concurrent aim to establish therapy teams comprising a Speech and Language Therapist and an Occupational Therapist resulted in a significant difference across the teams. Overall, this staffing resource model resulted in a number of challenges to the therapists in implementing the model as it was envisioned.

5.3 Induction, Staff Training & CPD

5.3.3 Key Achievements

1. Evidence of the development and use of training materials and resources focused on building knowledge and skills relevant to working in education environments.
2. An inter-disciplinary programme of induction to school-based practice made available in a short time-frame for therapy staff in the earliest phases of the project.
3. A demonstrated commitment to ongoing and continuous training for project staff evident throughout the first year of this project.

5.3.4 Findings

Findings confirmed that all therapists received an induction programme, as developed by the Project Team. Findings from the electronic questionnaire show that all the therapists received some training with 46% reporting satisfaction with this to a great or very great extent. A culture of continuous development and learning appears to have been encouraged with evidence of therapy staff engaged in collaborative workshops whereby they brainstormed ideas for implementing a tiered model in Irish school-based settings. Furthermore, there was evidence of a commitment to an ongoing CPD programme for project staff over the entirety of the school year, based on the identification of need as the project progressed. Much of the responsibility for facilitating such ongoing training and development appears to have rested with both clinical leads. Moreover, there was evidence that all the initial stages of the project saw therapy staff engaged in collaborative workshops whereby they brainstormed ideas for implementing a tiered model in Irish school-based settings.

The discipline-specific clinical leads, discipline-specific therapy managers and the Demonstration Project leader were responsible for identifying, coordinating and in many cases delivering[43] the vast majority of training from induction right through the course of the project. The nature of the orientation, induction and training processes appears to have created a collaborative, inter-disciplinary working culture between speech and language therapists and occupational therapists that will be of great benefit to the overall project. Much of the training and development reported upon was inter-disciplinary in nature and was well received by participating staff.

Data gathered during an early focus group with project therapists, the World Café and follow-up interviews with members of the management team did, however, reveal some anticipated challenges that were encountered as well as others that emerged over the reported lifetime of the project:

a) how to replicate a full induction programme for staff coming into the project during the school year

b) how to determine 'how much' training and support is required for new staff moving to delivering tiered-model interventions in education

c) how to determine appropriate outcomes and success indicators for staff induction, training and ongoing CPD.

From the therapist's interviews, their own capacity building was enhanced for working with educators, but many reported not knowing enough of the educational curriculum context to be able to translate their knowledge more effectively. This was a challenge noted in other tiered models also, where therapists identified the challenge of working differently and of the need to gain more insight and knowledge of the educational curriculum.[44]

Findings from the electronic questionnaire show that all the therapists received some training, with 46% receiving this to a great or very great extent. As a number of therapy staff came in late to the project, they do not appear to have received the same extent of training. Materials provided by the Demonstration Project confirmed that the initial induction programme focused on core readings relating to coaching and collaboration, essential knowledge such as child protection, and associated information sessions on the curriculum, and strategies for literacy or well-being for example. This was accompanied by information sessions on the role of the NCSE, DES inspectorate, DCYA, NEPS, amongst others.[45] The knowledge gained by therapists from such sessions was evidenced in the educators' survey data (ELC managers and school principals). When asked about the therapists' level of preparedness, many respondents reported that project therapists they encountered demonstrated a high level of relevant sectoral awareness.

43 Although much of the training and induction provided was delivered from within the team, there was also specialist knowledge delivered by staff from DCYA, NCSE, NEPS and other sectoral stakeholders. This served to complement the in-team generated training.

44 See for example, Campbell, W. N., Missiuna, Rivard and Pollock (2012).

45 Project Planning Document, Phase 1, 2018.

Through engaging with the induction processes in this project, therapy staff reported feeling highly competent in explaining the tiered model, identifying children with additional needs and translating knowledge to teachers and parents about strategies to assist children. Many commented that they were learning on the job, and that this has been the primary source of their knowledge development.

Provision for the number of therapy staff that came in late to the project appears to have been more challenging. Due to the timing of their employment, they missed brainstorming workshops held early in the project that served to assist with team-building and rapid upskilling. In its absence they were provided with alternative opportunities, although these were valued less than those available to their colleagues who came into the project at its inception. Some therapists on the project from its earliest stages expressed concern that those coming on board during the school year did not enjoy the same level of induction and domain-specific knowledge building and were concerned as to how this would translate into a skills deficit in their practice. In terms of the induction processes in this project, therapy staff reported[46] feeling highly competent in explaining the tiered model, identifying children with additional needs and translating knowledge to teachers and parents about strategies to assist children.

In a final point of note there was no evidence found of instances where staff or students from the educational settings or families were involved in the induction programme for the Demonstration Project. Other exemplars from international practice have incorporated this as a feature of induction and training, most notably the P4C project outlined previously.

5.4 Day-to-Day Management & Data Governance

5.4.1 Key Achievements

1. The Demonstration Project rapidly put in place management and supervisory functions and procedures while ensuring adherence to clinical governance, thus ensuring their ability to begin service delivery implementation early in the project lifespan.
2. The Demonstration Project Management Team put in place a data recording and storage system that ensured project compliance with national standards such as GDPR.
3. A bespoke mechanism for ensuring consent for service provision was developed by the management team during the lifetime of the project.
4. An electronic recording tool (Target Tracker) was developed to record and track the rollout of tiered interventions. This system was subject to ongoing iteration and update over the course of the project.

46 From World Café data and Therapists focus group.

5.4.2 Findings

The management of day-to-day operations for the project was centralised with a management team. The management team comprised two discipline-specific managers, two clinical leads, a project lead and a project manager. While therapists reported directly to their discipline-specific manager the project lead retained overall responsibility for the project implementation and progress. The role of the clinical lead position was less clear as clinical reporting and supervision responsibility was retained by each of the discipline-specific managers.

During the course of the evaluation, it was clear that confusion existed across the year in relation to understanding the distinct roles and responsibilities of the discipline-specific managers alongside the discipline-specific clinical leads. In contrast, within many health and social care services, typically staff of particular disciplines report to one hierarchical management structure (i.e. a manager with the same disciplinary background as themselves) that provides both management and clinical support through a single role. Some of the confusion was evident during the World Café with therapists, some noted that it was unclear to them "who to go to to ask about annual leave", and "with a problem, its not always 100% clear who to go to first."

The unique nature of this project created a challenge for clinical tasks such as note-taking, information recording and sharing amongst collegial professionals. At the outset of this project, the management team did not have a bespoke data management model and were required to develop their own system and processes as they began to initiate project activities. One key decision during the 'start-up' phase of this project was the introduction of the centralised 'Target Tracker' document where the targets (goals) being set for the participating schools and ELC settings could be mapped. This 'Target Tracker' was developed by both clinical leads and utilised a mainstream spreadsheet application.[47] The Target Tracker allowed both clinical leads visibility, on a periodic basis, of the nature and frequency of tiered interventions agreed between project therapists and the corresponding team in each setting. The Target Tracker developed, however useful as a tool, is not scalable as a solution in the long-term and is unlikely to provide the flexibility, stability or security required to manage large volumes of diverse data that requires deployment in multiple locations by a number of concurrent users.

In a series of hard-copy file reviews (n = 57 school files) conducted periodically by the evaluation team, examples of data duplication were identified, including entries from both Speech and Language Therapists and Occupational Therapists recording the same event or interaction with their allocated settings. The extent of the information gathered and held in each of the files was extensive and, in some instances, extended to several volumes of files. The physical size of each of the files posed challenges in terms of both storage and protection of the data located in each file.

A further finding that emerged from interviews with the project Management Team was that they had focused on implementing a data recording and management system that evolved from accepted practice for clinical recording. Although it was reported that the project teams

47 The Target Tracker was built as a linear, multi-data entry system using Microsoft Excel™ – a readily available and easy to use spreadsheet platform which provides the opportunity to display text and numerical data sets using graphing sets and allows for some manipulation of data and inter-data calculations.

at each school and ELC equipped staff at these locations with a project folder within which relevant documentation could be stored, these were not mentioned or made available during the site visits conducted by the evaluation team. Although detailed files on the work conducted at each location were centrally stored, it was not clear during the evaluation whether schools and ELCs would seek to access this data and it was not apparent that there were clear guidelines in place for the sharing of such information.

Furthermore, the evolving nature of the project saw issues emerge during its implementation relating to, for example access, consent, GDPR and storage. In such circumstances, the management team did not have an opportunity to reflect on and examine the nature of the data captured, what storage requirements were necessary and, crucially, the manner and nature of how this data would be accessed. This presented a range of complex data governance and access issues for the broad range of stakeholders involved in the project, requiring deliberation as to what access can or should be granted to elements of the recorded data within the existing data governance structures that are in place for both DES and the HSE.

The cross-sectoral nature of the project also posed challenges for how data was recorded, managed and accessed throughout the project resulting in the management team dedicating ongoing resources to resolve throughout the project. The issue of which staff could access files and other recorded data consequently resulted in a situation late in the project (May 2019) where issues and questions emerged as to what staff had or should have had access to elements of the data being recorded. The nature of this issue was such that it required escalation to the project Working Group for resolution; however, by the end of the project, the evaluation team did not see a full resolution to this issue. Arrangements in terms of data access and sharing were not fully resolved by the end of the project. Such challenges are of concern to the long-term development of service delivery models such as this and require pre-emptive resolution to ensure the ongoing smooth performance of the project Management Team. However, this would be expected in a complex project developing new processes drawn from the various agencies involved.

5.5 School/ELC Engagement

5.5.1 Key Achievements

1. Evidence of operational project teams representing partnership between Demonstration Project therapy staff and on-site education staff established in a majority of participant settings.
2. Evidence of an effective strategy to build awareness and understanding of the model of service delivery amongst staff at participant settings.
3. Evidence of a collaborative approach to establishing a needs assessment at a majority of project sites.

5.5.2 Findings

International evidence and guidance from the NCSE suggest that the school engagement or 'consultation phase' is considered a fundamental component for the successful implementation of a project of this nature (Missiuna et al., 2015). The consultation phase comprises a) informing service recipients about the nature of the project and b) relationship building, leading to an assessment of need. Findings from the interviews and electronic questionnaire confirm that this Project was committed to a school engagement model that included informing service recipients about the nature of the project, ongoing establishment of project teams and beginning a needs-assessment process to determine what interventions should be provided.

Analysis of data from the interviews with ELC managers and school principals and further data gathered from electronic questionnaires sent to staff at participating settings confirm that this Project dedicated effort and resources to a range of actions that sought to increase awareness and understanding of the proposed project to stakeholders within participating schools and ELCs (Demonstration Project Working Group, 2018).[48] Of note are the recorded 75 information sessions provided at schools and in a range of convenient locations such as local hotels, at which over 1,155 teachers/educators were in attendance. These sessions covered a range of topics from providing an overview of the project through to more specific training in areas such as Elkan, Hanen and sensory awareness. These CPD and information sessions continued through until the end of January 2020. Furthermore, a range of information and awareness resources were developed including information letters to school principals.[49] Two introductory information sessions for principals/managers of the 150 sites (September 2018) were developed and delivered, and materials were developed to provide these to schools as a mechanism for introducing and explaining the tiered model that underpinned the new service delivery model to parents and educators. The management team identified and developed a range of written resources that could be provided to staff from participating settings. These resources were circulated to schools directly in some circumstances and during two information sessions on the 13th and 18th of September 2018. The actions reported above went some way in addressing an awareness of the project, the tiered approach to service delivery and the overall rollout of the service. The relatively short lead-in time and the fact that the commencement of engagement with schools and ELCs coincided with the traditional start of the school year, meant that the early phases of engagement with schools focused on building awareness and understanding of the project and the proposed model of service delivery.

Analysis of interviews with school principals and ELC managers, and the World Café focus group, alongside data gathered during school/ELC visits, indicated clearly that participant settings expected that inclusion in this project would ensure rapid access to Speech and Language Therapy and Occupational Therapy services. While this was one of the expressed aims of the project, the nature of such a service required further understanding and awareness on the part of school and ELC staff. In many instances, school staff indicated that they expected that individual children would benefit directly from provision of on-site, one-to-one therapy.[50] As such, their initial expectations of their participation in the Demonstration Project were not aligned with the vision

48 Information received from interview with project manager, January 2019.

49 Final letter to schools May 2018: Demonstration Project on In-school and Preschool Therapy Support.

50 Which reflects their understanding of how therapy is typically delivered.

and objectives of that project, which is to be expected. Again, the timing of the commencement of the project must be considered in light of these findings. The project initiation and early school engagement as mentioned earlier coincided with one of the busiest times of the year for schools and ELCs. School staff for the most part still reported a general lack of awareness of the tiered model of service provision during the project, and felt that they had limited opportunity or time available to review the provided documentation and, most importantly, apply this to their own setting ahead of the commencement of the project.

Staff feedback from all sectors highlighted the need for more extensive, relevant documentation for consideration by ELC/school leadership. Although information sessions were welcomed by most participant respondents, ELC managers and school principals expressed a desire for further introductory sessions with clear outlines of their responsibilities in the project and a clear definition of the expectations of the time that would be expected of individual staff members. Furthermore, ELCs and school staff felt that the information resources provided were inadequate in clearly outlining their responsibilities, and opportunities to discuss and negotiate these were very limited due to the time constraints enforced due to the commencement date for the Demonstration Project.

For this Demonstration Project, and similar to RtI, a project team[51] was planned for each site and was one of the first targets undertaken by each therapist team. The purpose of establishing a project team with representation from the therapy staff in the Demonstration Project and staff based in individual settings was to provide a platform for which the project activities could be operationalised at each site. In the project documentation plan for January 2019, a key element listed was the ongoing need to establish project teams.[52] Evidence from the spot-check file analysis in April showed that project teams were in-situ in 28 of the 37 files, which constitutes a 76% completion rate, while evidence from the case study file analysis showed that project teams in-situ were evident in 16 of the 20 files, which constitutes an 84.2% completion rate. Due to differences in documentation across files, it is not possible to establish clearly how many sites had project teams in place, or whether the files had accurately recorded the presence or absence of project teams. From review of the data recorded in school/setting charts, it was evident that project teams included different member(s) of staff depending on the site. This was to be expected, and reflected the heterogeneous nature of the participating schools and ELCs. Project teams generally consisted of a project lead (primarily principal/manager/SEN coordinators) in addition to other staff members (primarily deputy principals/Early Years Practitioners/special education teachers/mainstream teachers). As was evident in analysis of the Target Tracker,[53] efforts to establish project teams (at participant locations) were identified

51 Although documentation reviewed during the early part of this evaluation project did not indicate or define the term project team, this term was used to describe an operational group set up in each of the participant locations. Project teams were established during the early engagement phases of the project and comprised the therapists and members of staff of the participating setting. No documentation was uncovered that articulated the composition, membership, terms and conditions or roles and responsibilities of these teams. Subsequent data gathering suggests that the primary function of the project team included identifying the needs of the participant setting, put in place a plan to address this and to manage the ongoing relationship between the setting and the Demonstration Project.

52 Demonstration Project on In-school and Early years Therapy Support Project Plan, 2018-2019, Stage 2, NCSE, 2018, provided by Project Team.

53 In particular, early analysis of the Target Tracker data highlighted a range of activities by therapists with schools and ELC staff that focussed on awareness building and increasing understanding of the aims and scope of the Demonstration Project. Although many of these were referred to as CPD activities or other Tier 1 interventions, further discussion and interviews with therapists and with staff at participant locations highlighted that the main focus for these was to ensure the establishment and effective working of project teams to implement or guide delivery of tiered services.

as a facilitating factor for the implementation of the Demonstration Project and the subsequent achievement of targets. It was unclear from the evidence whether ongoing project team meetings were held during the year to monitor progress as was done in RtI. Overall, the role of individual project teams appears to have been of a bespoke nature so as to be responsive to local conditions and requirements of the particular school or ELC.

Educator respondents noted in surveys that once therapy staff were allocated to their schools/ ELC settings, they continued to implement a school engagement process that included a needs assessment. Survey data from the educators reported that 87% of sites had a needs assessment. From the file analysis, evidence of completed whole-setting surveys was evident in 77.1% of settings. The main method adopted for the needs appears to be the use of a staff survey, while some settings reported parental or child engagement as part of the needs assessment process. In an analysis of 57 setting files conducted in April, July and September, six different types of surveys (needs assessments) were evident in these hard-copy files,[54] with an inconsistent completion profile – the establishment of agreed goals and objectives as an outcome of the surveys was not evident in all the files.[55]

Across the case study sample files reviewed (n=20), only nine files contained information about the total numbers of children in the setting. Only six settings had the total numbers and types of staff identified. Yet the range of staff and student numbers across ELC to post-primary settings varied significantly and would contribute to an analysis of potential workload demand.[56] Furthermore, therapist respondents identified 'relationship building' as a core feature of Tier 1 supports. However, they also noted that the number of settings participating in the project was influencing the time that they could spend in individual settings. Therapy staff in this Demonstration Project had up to 13 settings allocated to them[57], which challenged their capacity to spend full days in schools on a weekly basis.

5.6 Implementation of Tiered Service Delivery

5.6.1 Findings

The Demonstration Project was designed such that tiered interventions would be delivered in a phased way. According to the project plans for this Demonstration Project (see Appendix I), the priority was to implement Tier 1 in addition to establishing the project (Action 11)[58] from August 2018 to January 2019. The plan was to then implement Tiers 2 and 3 in spring, 2019. The phased approach was in response to the scope of the project with a high number of settings to cover relative to the number of therapists working on the project. This phased approach is also

54 These included: (i) Early Years practitioner survey, (ii) school-wide review tool, (iii) school-wide review survey, (iv) whole-setting review and target setting tool, (v) whole-school communication review and target setting tool and (vi) post-primary school wide review tool.

55 For example, in the case study review of 20 sites, only four settings had a summary of the survey on file.

56 This needs assessment was further defined as Tier 1 therapy services, and documented in the Target Tracker as a Tier 1 intervention.

57 Findings from electronic questionnaire with therapy staff.

58 Demonstration Project on In-school and Early years Therapy Support Project Plan, 2018-2019, Stage 2, NCSE, 2018; provided by Project Team.

seen in RtI models as noted in Section 3, where a gradual process of implementation is used to establish a tiered programme within specific settings. As noted below, the outcome was that by July, Tier 3 was in the early stages of implementation with 16% of settings having established Tier 3 targets and consequently the full implementation of a multi-tier model was beginning to emerge by the end of the year.

Several factors appeared to contribute to the situation where the majority of settings did not experience therapy provision on a regular weekly basis, including changes to project teams that came about as a consequence of changes in staffing that occurred for a variety of reasons, including therapists changing jobs and taking service breaks such as maternity leave during the year. As such there was rarely a full complement of therapists in place, resulting in the overall workload having to be aggregated across the remaining therapy team. This impacted teams' ability to maintain the regular contact essential to the success of such a project, particularly in the early stages of engagement.

From chart analysis data, the total number of face-to-face contacts in the first seven months was 425, which averages at approximately 12 face-to-face contacts per setting from September to March, with more frequent visits occurring in the spring term. However, one solution that emerged was the development of 'drop-in' clinics as a strategy that aimed for regular contact time in each setting. Therapists were unable to attend weekly due to the workload so instead aimed to attend on a fortnightly basis at a fixed time to help facilitate collaboration. Although this is not based on the evidence (which is based commonly on a weekly presence), it is an example of how therapy provision can be still provided regularly on-site without relying on a specific scheduled CPD event for example or requiring an appointment to be there

Target Tracker data provided evidence of more specific detail on the implementation of the project from the outset. Tracker data showed that therapy staff began in the first phase by being asked to select the area targeted in their intervention from a list of 13 pre-defined types of targets ('areas targeted'), such as whole-school CPD or parental engagement. By the end of the year, this list ranged from 17 to 28 areas targeted. This reflected the maturation of the model of delivery and an increased understanding of the scope of interventions at all three tiers that comprise the model.

By July 2019, a combined 1,736 targets were set across the four setting types (i.e. ELC settings, primary schools, post-primary schools and special schools). A greater number of targets were set for ELC settings (n = 897) than school settings (n = 839) (see Table 5.2). As of July 2019, the average number of targets set ranged from 0.01 to 9.26 targets for each of the participating settings. Proportionally, post-primary schools had fewer targets; ELC settings and primary schools had more targets.

Table 5.2: Targets by Setting Type

	January 2019 (n = 814)				March 2019 (n = 1,252)				April 2019 (n = 1,392)				July 2019 (n = 1,736)			
	T1	T2	T3	ND	T1	T2	T3	ND	T1	T2	T3	ND	T1	T2	T3	ND
ELC	365	20	–	–	546	39	45	16	580	49	70	–	685	60	151	1
PS	291	36	–	–	372	80	15	–	397	107	35	1	420	129	116	3
PPS	59	10	–	–	79	13	2	–	81	16	3	–	88	16	5	–
SS	28	5	–	–	35	10	–	–	39	13	1	–	42	14	6	–

By July 2019, a combined 1,235 (71.1%) targets were set at Tier 1 across the four setting types, suggesting that Tier 1 interventions were embedded in all setting types during the 2018/2019 school year. In addition, by July 2019, a combined 219 (12.6%) targets were set at Tier 2 across the four setting types, suggesting that Tier 2 interventions were somewhat embedded in all setting types during the 2018/2019 school year. Furthermore, by July 2019, a combined 278 (16.3%) targets were set at Tier 3 across the four setting types, suggesting that Tier 3 interventions were, for the most part, targeted in all setting types towards the end of the 2018/2019 school year. These findings suggest that while Tier 1 had been implemented across the 2018/2019 school year, Tier 2 interventions were more specifically targeted in all setting types from March through to July inclusive. Moreover, Tier 3 interventions were more specifically targeted in all setting types towards the end of the 2018/2019 school year (i.e. from April to July inclusive). Considering the decision made to implement the rollout of the therapy service, this was to be anticipated.

While the project documentation confirms the need to first try Tier 1 and Tier 2 interventions to monitor the child's responses before Tier 3 is implemented, the clinical decision-making that informed a child's need for Tier 3 interventions was more difficult to ascertain. In relation to Target Tracker documentation, in January 2019, no Tier 3 targets had been set. As of July, a combined 278 targets were set at Tier 3. This finding strongly suggests that Tier 3 interventions were more specifically targeted in all setting types towards the end of the 2018/2019 school year (i.e. from April to July inclusive). Adherence to rolling out the implementation on a tier by tier basis meant that Tier 3 interventions had the shortest time-frame for rollout and were being delivered at a time where the routine of the school was interrupted by events such as exams, school sports days and school outings. This is reflected in the low numbers of targets set during this time and was reflected in the numbers of visits recorded in charts reviewed. It should be noted that this cannot be construed as a reflection of the need for Tier 3 interventions in schools. In fact, interviews with school and ELC staff reported their frustration that more time was not available to explore interventions at this level. School-based staff also reported that they were actively engaged in planning exercises during the same period to ensure that project therapists allocated to their setting would be in a position to begin such interventions in the new school year.

This pattern across the analysis of the implementation is reflective of the phased rollout, but it also reflects some other contextual factors that were encountered during the project. In ELC settings, many of the interventions were documented as Tier 1 or Tier 3, and this seems to be due to a number of contextual considerations. Firstly, the fact that the ELC settings are already small group settings compared to the larger primary and secondary school sites influences what is considered a whole-school or small group approach. As we know, Tier 2 involves taking a smaller group of children rather than the whole class, to do more focused work. This is already possible in an ELC setting as a whole-school approach. Secondly, children attending ELC settings fall into the early intervention category in any health context, as they are often too young to receive formal diagnoses yet would be considered as appropriate for a Tier 3 approach. Therefore, those pre-school age children who need more intensive interventions (children who present with learning needs) can be described as needing Tier 3 interventions. The application of a tiered model equally across such a broad range of ages and stages is something that arises from this evaluation as needing further examination and clarification, and is not so clearly debated in the international evidence. Further challenges are also inherent in relying on an interpretation of the targets at each tier. For example, it is important to note that children who need Tier 3 interventions may achieve their goal and revert to being involved in Tier 2 or Tier 1 interventions, so the data analysis of each tier is only a snapshot of any specific time.

5.6.1.1 Tier 1 Implementation – Key Achievements

1. Evidence of the awareness of Tier 1 interventions increased across the project.
2. Project staff identified 1,235 Tier 1 interventions across all participating settings.
3. There was evidence that Tier 1 interventions continued throughout the project.
4. There was evidence of capacity building achieved across all 150 sites due to successful roll-out of the CPD programme throughout the participating settings.
5. Examples of collaborative consultation became evident as the project progressed.

5.6.1.2 Tier 1 Implementation: Findings

In January 2019, 741 Tier 1 targets were set across the four setting types (see Table 5.3). As of July 1,235 Tier 1 targets were set, constituting an increase of 494 Tier 1 targets during the 2018/2019 school year. This finding strongly suggests that Tier 1 remained ongoing in settings, particularly in ELC settings, over the course of the 2018/2019 school year. Moreover, the most frequently targeted areas across all setting types included the provision of whole-school CPD and the identification of needs. From the chart analysis, whole-school CPD was frequently the target set that referred to a workshop that aimed to introduce the project and explain the role of the therapists in a tiered model. Furthermore, identification of need was listed as a Tier 1 target, alongside establishing a project team. These three targets are examples of Tier 1 interventions that are not reflective of Tier 1 interventions. In international tiered models, these three targets are more typically associated with the earlier phase of establishing a tiered model.

Of the 1,235 Tier 1 targets set and agreed between the Demonstration Project and beneficiary schools and sites, 685 of these were for ELCs, 420 were for primary schools, 88 for post-primary and 42 for special schools.

Table 5.3: Tier 1 Areas Targeted Across All Setting Types

Areas targeted	ELC (n = 74)				PS (n = 53)				PPS (n = 15)				SS (n = 6)			
	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul
Developing project team	30	33	30	35	25	27	28	22	7	7	7	6	3	3	3	2
Whole-school CPD	99	112	109	116	98	125	127	121	15	16	16	17	6	9	9	11
Specific CPD	19	64	66	74	19	28	36	40	3	7	6	10	4	5	5	5
Whole-school programme	7	10	12	13	1	5	6	7	–	–	–	–	1	1	1	2
Whole-school initiative	40	61	65	87	38	44	47	48	13	13	15	15	6	8	11	9
School environment – social areas	–	1	3	5	6	4	4	5	1	1	1	1	–	–	–	–
School environment – classrooms	24	33	34	39	6	10	9	12	–	1	1	1	–	–	–	–
Identifying needs	77	86	85	91	62	67	68	78	11	15	15	15	6	4	5	6
Targeted programme – whole class	6	21	24	39	5	10	14	16	2	5	7	8	1	1	1	2
Targeted programme – group	–	1	3	1	2	3	3	3	3	5	5	6	–	–	–	–
Targeted programme – classroom	–	–	–	–	5	5	6	4	–	–	–	–	–	–	–	–
Specific skills coaching/ In-class modelling	30	64	77	90	12	15	20	20	1	1	1	1	1	1	2	2
Parental engagement	32	58	70	94	8	21	23	33	–	1	1	2	–	1	–	1
Individualised planning	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–
Individualised programme	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Individualised support	–	–	–	–	1	1	1	3	–	–	–	1	–	–	–	–
Student engagement	1	1	1	1	1	1	1	1	3	4	4	4	–	–	–	–
Targeted programme (Talk Time) – two identified classrooms	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Specific class identified	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Observation of targeted group	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–

Areas targeted	ELC (n = 74)				PS (n = 53)				PPS (n = 15)				SS (n = 6)			
	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul
Universal information session	–	–	–	–	–	2	2	2	–	–	–	–	–	–	–	–
School environment yard audit and survey feedback	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Discussed the Demonstration Project	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–
Information sharing with whole staff	–	–	–	–	–	–	–	–	–	1	1	1	–	–	–	–
Gathering information. Building rapport. School tour.	–	–	–	–	–	–	–	–	–	–	–	–	–	1	1	1
Observation of breakfast club	–	–	–	–	–	–	–	–	–	–	–	–	–	1	1	1
Total				**685**				**421**				**88**				**42**

From the sample chart analysis, the majority of settings had received other Tier 1 interventions that are consistent with their descriptions in the published literature, such as scheduled CPD sessions on knowledge-based content regarding Speech and Language Therapy and Occupational Therapy, environmental adaptations, whole-school initiatives such as Talk Time, or self-regulation strategies. In addition, these interventions align with the aims of the Demonstration Project, which were to provide universal support for all children through professional development relating to the educational needs of the school. These descriptions are corroborated in the other documentation such as Target Tracker and charts, for example, supporting an ELC staff to develop resources for story time and movement breaks or toileting strategies. These interventions are examples of an alignment also with the ELC Aistear curriculum for well-being, exploring and learning. In addition, they reflect a focus on capacity building and whole-school interventions. All of these approaches are established as potentially appropriate tiered approaches for school-based practice as long as they are embedded in a collaborative consultation approach consistent with reports from international literature. In addition, these interventions align with the aims of the Demonstration Project, which was to provide universal support for all children through professional development relating to the educational needs of the school.

Review of charts and data from the Target Tracker indicated that by the end of the year, there was evidence of collaborative consultation evolving as the tiered model was fully rolled out. However, from the therapists' interviews and survey data, many reported not having enough knowledge of the educational curricula to be able to translate their expertise more effectively.[59] Data from educational staff focus groups further corroborated this evidence when they identified that therapists proposed many ideas and solutions, but often did not know what would work in a whole-class context or know how to tailor their therapy strategies for a school context.

59 Note that collaborative consultation if effective, results in knowledge translation for both therapists and educators.

This was a challenge noted in other tiered models also, where therapists identified the challenge of working differently and of the need to gain more insight and knowledge of educational curricula.[60]

5.6.2 Tier 2 Implementation

5.6.2.1 Key Achievements

1. There was evidence of increasing collaborative working practice between educators and therapy staff.
2. Interventions to support access to the curriculum were introduced on a more systematic basis, supported by in-class modelling, information provision and resource provision.
3. There was evidence of the establishment of small group work interventions targeting 'at risk' groups.
4. Work was completed on a comprehensive consent for service protocol and integrated into operational practice.

5.6.2.2 Tier 2 Implementation: Findings

In January 2019, 68 Tier 2 targets were set across the four setting types (see Table 5.4). As of July, a combined 220 Tier 2 targets were set constituting an increase of 152 Tier 2 targets. This finding strongly suggests that Tier 2 interventions were more specifically targeted in all setting types from March through July inclusive. Moreover, the most frequently targeted area(s) across all setting types included targeted programmes for whole classes and groups.

Table 5.4: Tier 2 Areas Targeted Across All Setting Types

Areas targeted	ELC (n = 74)				PS (n = 53)				PPS (n = 15)				SS (n = 6)			
	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul
Whole-school CPD	–	–	–	–	1	4	3	4	–	–	–	–	–	–	–	–
Specific CPD	–	–	–	–	3	6	6	6	–	–	3	2	–	–	–	–
Whole-school initiative	–	–	–	–	2	4	5	4	–	–	–	–	–	–	–	–
School environment – classrooms	3	3	3	3	1	1	2	2	–	–	–	–	–	–	–	–
Identifying needs	1	2	2	2	–	2	3	7	1	1	1	1	–	–	–	–
Targeted programme – whole class	8	14	19	15	15	27	28	32	2	6	4	5	4	5	6	5

60 See for example, Campbell et al., 2012).

Areas targeted	ELC (n = 74)				PS (n = 53)				PPS (n = 15)				SS (n = 6)			
	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul
Targeted programme – group	5	10	9	20	9	19	34	37	3	5	5	5	1	3	3	4
Specific skills coaching/In-class modelling	2	9	14	18	2	12	19	26	2	3	3	3	–	2	3	4
Parental engagement	–	–	1	1	2	2	2	5	–	–	–	–	–	–	1	1
Individualised planning	1	1	1	1	–	–	1	3	–	–	–	–	–	–	–	–
Individualised programme	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Individualised support	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–
Specific class identified	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Observation of targeted group	–	–	–	–	–	1	1	1	–	–	–	–	–	–	–	–
Targeted group	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–
Total				**60**				**130**				**16**				**14**

Overall, interventions described by therapy staff for the Demonstration Project appear to align with the international literature that articulates Tier 2 interventions being targeted, and for groups at risk. However, some confusion was evident in certain service provision descriptions. For example, goal-setting for individual children is named here as Tier 2, whereas goal-setting fits more in a Tier 3. Furthermore, some interventions described by the therapy staff are considered to be Tier 1 interventions in the literature. As with Tier 1, these descriptions were corroborated in other documentation such as Target Tracker and charts. For example, in Occupational Therapy, a small group programme for self-regulation in sensory rooms and a sensory circuit was set up. In Speech and Language Therapy, teaching strategies from Talk Time and Language Land programmes were modelled, there were targeted active listening groups and transitioning groups for moving to school/secondary school. From the chart analysis, it was clear that many interventions delivered at Tier 2 focused on delivering therapy in small groups of targeted children who needed extra input, modelling teaching or strategies for educators and engaging parents for those considered to be at risk. The Target Tracker also revealed that inter-disciplinary work was occurring at Tier 2, which primarily involved therapist-educator targets, rather than across Occupational Therapy and Speech and Language Therapy.

Some examples of Tier 2 interventions recorded in files examined did not refer to differentiated instruction or adapting the curriculum, which was one of the features, described in the Demonstration Project materials and is a characteristic of a tiered model in international literature. In many cases Tier 2 interventions were described as strategies provided by the

therapists such as vocabulary development, behaviour, language enrichment, handwriting and sensory strategies and group work related to zones of regulation. Therapists explained these Tier 2 interventions as withdrawal: small group interventions targeting skill deficits. These are examples of traditional therapy approaches that are also delivered in therapy clinics. The main difference between the traditional approaches and the Demonstration Project is that in the schools, the therapists were including the educators in the training and delivery of these therapy approaches. While these have a place in overall therapy provision, school-based practice in a tiered model requires a more embedded education-oriented approach to support inclusion (as outlined in Table 3.2).

5.6.3 Tier 3 Implementation

5.6.3.1 Key Achievements

1. There was evidence of individual targets set for children from 16% of participant settings.
2. There was evidence of therapists extending work to more actively include parents and third-party service providers and stakeholders.
3. Implementation of Tier 3 interventions in participant settings represents the delivery of the proposed tiered model in its entirety as a fully functioning multi-tier model of therapy support and service delivery to children in schools and ELCs.

5.6.3.2 Summary of Findings

The findings as they relate to the implementation of Tier 3 interventions must be prefaced by acknowledgement of the impact that processes external to the project had on the day-to-day operation of the Demonstration Project. During the second half of the project the evaluation team were made aware that FORSA, the industrial relations organisation representing Special Needs Assistants, were in ongoing discussions with the DES with regard to the implementation of a range of new work practices in schools. During these discussions, it was reported that more than 30 of the 75 participating schools temporarily withdrew from the project halting all project activities. The impact that such a disruption had on the overall project was not anticipated at the outset and as such was beyond the scope of examination of the evaluation team. Nonetheless, the impact this action had on the achievements accrued in the Demonstration Project cannot be underestimated.

As is evident from Table 5.5 below, no Tier 3 targets were set during the early stages of implementation of the tiered model (i.e. September 2018 to January 2019). As of July, a combined 279 Tier 3 targets were set across the four setting types. This finding strongly suggests that Tier 3 interventions were more specifically targeted in all setting types towards the end of the 2018/2019 school year (i.e. from April to July inclusive). Moreover, as would be expected for interventions that are more individualised in nature, the most frequently targeted area(s) across all setting types included the provision of individualised support (including linking with external services) and individualised planning.

Table 5.5: Tier 3 Areas Targeted Across All Setting Types

Areas targeted	ELC (n = 74)				PS (n = 53)				PPS (n = 15)				SS (n = 6)			
	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul	Jan	Mar	Apr	Jul
School environment – social areas	–	–	–	–	–	–	–	2	–	–	–	–	–	–	–	–
Identifying needs	–	–	–	7	–	1	1	11	–	–	–	1	–	–	–	–
Targeted programme – whole class	–	2	1	1	–	–	–	–	–	–	–	–	–	–	–	–
Targeted programme – group	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–
Specific skills coaching/In-class modelling	–	1	2	3	–	–	1	1	–	–	–	–	–	–	–	–
Parental engagement	–	1	1	2	–	2	2	4	–	–	–	–	–	–	–	–
Individualised planning	–	8	12	33	–	3	12	31	–	–	1	1	–	–	1	5
Individualised programme	–	1	2	5	–	–	–	3	–	–	–	–	–	–	–	–
Individualised support	–	32	52	99	–	8	19	64	–	2	2	3	–	–	–	1
Student engagement	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–
Total				**151**				**117**				**5**				**6**

Overall, interventions described by therapy staff for the Demonstration Project appear to align with the international literature that articulates Tier 3 interventions. In the Demonstration Project written documentation, Tier 3 was described in a similar way to the international literature, where it was described as consisting of an intensive approach that is oriented for individual children with significant needs, alongside working with outside agencies, with some focus on intensive instruction relating to the curriculum and IEPs. Tier 3 therapy supports as described in the tiered model of service delivery are underpinned by principles of collaborative consultation and co-teaching or coaching. Interviews with the Project Management team were cognisant of this difference from traditional practice. It is acknowledged that Tier 3 interventions can appear to align closely with traditional clinic-based practice as they are focused on children with identified diagnoses and learning needs. Establishing a clear distinction between what constitutes clinic-based and school-based services presented a challenge for practice. The role of 'assessment' appeared to lack consensus and lacked clarity. It was described by therapists as being a controversial issue of discussion amongst the team and subject to debate and differing interpretation. In the staff survey some respondents reported it was important for diagnostic baseline information while others viewed it as having a role in screening and being 'solution-

focused'. During interviews therapy staff noted that it was difficult to 'supplement' Tier 3 interventions for children with identified needs when they were already waiting for external services and not getting any direct/individualised treatment. Therapy staff during the evaluation seemed to find this a challenge to understand the different roles that were emerging. They noted that it was difficult implementing Tier 3 interventions for children with identified needs in relation to their separate role from community-based therapy supports, and in diagnostics and assessment. In interviews with members of the steering group, it was reported that therapists were reluctant to intervene where a child was involved with a community-based therapist, and the net effect of a lack of clear guidance could result in children remaining on a long waiting list. Beyond the issue of assessment, data gathered during the World Café indicated that project therapy staff felt they had the requisite skills to implement Tier 3 solutions. Therapists also reported that although they felt equipped to implement such solutions at an earlier stage of the project, they understood the need to first build capacity delivering Tiers 1 and 2.

Examples of Tier 3 interventions from the educator surveys and from chart analysis included awareness building, individual support for language, personalised self-regulation strategies for children, specific Hanen programmes, group work or referral to community services. From chart and Target Tracker documentation, examples included classroom observations to identify a child's needs with handwriting, and to provide strategies for remediation; individualised support for a child and follow up with an external service; supporting teacher to implement a Smart Moves programme during special education hour to increase child's confidence during PE; to support a teacher to develop language in a child with ASD; providing support to an educator to implement an external Speech and Language programme in school. These all reflect the strength of a school-based therapy service as they maximise the impact and potential for the child to make gains in the natural setting and context in which they are required to perform to their abilities.

5.6.4 Overall Summary of Findings Tier 1-3

The following section further outlines findings regarding the implementation of the tiered model at the heart of the Demonstration Project. Further details are provided in terms of the types of targets set, the status of such targets reflecting the numbers which were completed, and an analysis of the discipline responsible for these.

The data presented below represents an analysis of the Target Tracker as it reflected effort on the project from September 2018 through to July 2019 and is supplemented with data gathered from chart analysis that was conducted during June and July 2019.

5.6.4.1 Areas Targeted

By July 2019, a combined 1,736 targets were set across the four setting types (i.e. ELC settings, primary schools, post-primary schools and special schools) (see Table 5.17). A greater number of targets were set for ELC settings (n = 897) than school settings (n = 839). As of July 2019, the average number of targets set ranged from 0.01 to 9.26 targets; proportion wise, post-primary schools had fewer targets, ELC settings and primary schools had more targets (see Table 5.6).

Table 5.6: Targets by Setting Type

	January 2019 (n = 814)				March 2019 (n = 1,252)				April 2019 (n = 1,392)				July 2019 (n = 1,736)			
	T1	T2	T3	ND	T1	T2	T3	ND	T1	T2	T3	ND	T1	T2	T3	ND
ELC	365	20	–	–	546	39	45	16	580	47	69	–	685	60	151	1
Av.	5.37	0.29	–	–	7.38	0.53	0.61	0.22	7.84	0.64	0.93	–	9.26	0.81	2.04	0.01
PS	291	36	–	–	372	80	15	–	397	107	35	1	420	129	116	3
Av.	5.39	0.67	–	–	6.89	1.48	0.28	–	7.35	1.98	0.65	0.02	7.92	2.43	2.19	0.06
PPS	59	10	–	–	79	13	2	–	81	16	3	–	88	16	5	–
Av.	3.93	0.67	–	–	5.27	0.87	0.13	–	5.4	1.07	0.2	–	5.87	1.07	0.33	–
SS	28	5	–	–	35	10	–	–	39	13	1	–	42	14	6	–
Av.	4.67	0.83	–	–	5.83	1.67	–	–	6.5	2.17	0.17	–	7	2.33	1	–

By July 2019, a combined 1,235 (71.1%) targets were set at Tier 1 across the four setting types, suggesting that Tier 1 interventions were embedded in all setting types during the 2018/2019 school year. Moreover, by July 2019, a combined 219 (12.6%) targets were set at Tier 2 across the four setting types, suggesting that Tier 2 interventions were somewhat embedded in all setting types over the 2018/2019 school year. In addition, by July 2019, a combined 278 (16.0%) targets were set at Tier 3 across the four setting types, suggesting that Tier 3 interventions were, for the most part, targeted in all setting types towards the end of the 2018/2019 school year. These findings suggest that while Tier 1 had been implemented across the 2018/2019 school year, Tier 2 interventions were more specifically targeted in all setting types from March through July inclusive. Moreover, Tier 3 interventions were more specifically targeted in all setting types towards the end of the 2018/2019 school year (i.e. from April through July inclusive).

ELCs: The most frequently targeted areas in ELCs were the provision of whole-school CPD and the identification of needs. Moreover, the provision of specific CPD, specific skills coaching/ in-class modelling, whole-school initiatives and parental engagement were more specifically targeted from January to July.

Primary Schools: the most frequently targeted areas in primary schools were the provision of whole-school CPD, whole-school initiatives and the identification of needs (see Items 2, 4 and 8). Moreover, the provision of specific CPD, targeted programmes (whole class and group) and parental engagement were more specifically targeted after January.

Post-Primary Schools: the most frequently targeted areas in post-primary schools were the provision of whole-school CPD, whole-school initiatives and the identification of needs (see Items 2, 4 and 8). Moreover, the provision of individualised support and targeted, small-group interventions emerged towards the latter stages of the project.

Special Schools: the most frequently targeted areas in special schools were the provision of whole-school CPD and the identification of needs (see Items 2 and 8). Moreover, the provision of whole-school initiatives, targeted programmes (whole class) and specific skills coaching/in-class modelling were more specifically targeted from March to July.

5.6.4.2 Status of Targets

In January 2019, the majority of targets were reported as partially achieved/ongoing/not defined across all settings (434, 53.3%); a further 352 (43.2%) were reported as having been achieved. By July 2019, the majority of targets set were reported as being achieved (1,141, 65.7%), a further 595 targets (34.3%) were reported as partially achieved (449, 25.9%), not achieved (132, 7.6%) or not defined (14, 0.8%).

ELCs: By July 2019, all tiers were operationalised in several of the ELC settings. The majority of targets set were Tier 1 targets (685, 76.4%); a further 211 targets were set at Tier 2 (60, 6.7%) and Tier 3 (151, 16.8%). This finding suggests the tiered model was being operationalised at all tiers in ELC settings. By July 2019 the majority of targets set were reported as being achieved (594, 66.2%). However, a further 303 targets (33.8%) were reported as partially achieved (233, 26.0%), not achieved (66, 7.4%) or not defined (4, 0.4%).

Primary Schools: By July 2019, 668 targets had been set across the 53 primary schools. The vast majority of targets set were Tier 1 targets (420, 62.9%); a further 245 targets were set at Tier 2 (129, 19.3%) and Tier 3 (116, 17.4%). By July 2019 the majority of targets set were reported as being achieved (450, 67.4%). However, a further 218 targets (32.6%) were reported as partially achieved (165, 24.7%), not achieved (48, 7.2%) or not defined (5, 0.7%).

Post-Primary Schools: By July 2019, 109 targets had been set across the 15 post-primary schools. The vast majority of targets set were Tier 1 targets (88, 80.7%); a further 21 targets were set at Tier 2 (16, 14.7%) and Tier 3 (5, 4.6%). As evidenced in Table 5.12 below, by July 2019 the majority of targets set were reported as being achieved (63, 57.8%). However, a further 46 targets (42.2%) were reported as partially achieved (31, 28.4%), not achieved (12, 11.0%) or not defined (3, 2.8%).

Special Schools: By July 2019, 62 targets had been set across the 6 special schools. The vast majority of targets set were Tier 1 targets (42, 67.7%); a further 20 targets were set at Tier 2 (14, 22.6%) and Tier 3 (6, 9.7%). by July 2019 the majority of targets set were reported as being achieved (34, 54.8%). However, a further 28 targets (45.2%) were reported as partially achieved (20, 32.3%), not achieved (6, 9.7%) or not defined (2, 3.2%).

5.6.4.3 Those Responsible for the Target(s)

While the early stages of the project saw many of the targets being the joint responsibility of Speech and Language Therapy and Occupational Therapy staff, from March through July inclusive, a majority of the targets set were discipline-specific targets. It is not surprising that a greater number of targets set were discipline-specific targets given that the therapy staff were providing a greater number of Tier 2 and Tier 3 supports that warranted more discipline-specific

intervention (for example, motor skills for Occupational Therapy, language and communication for Speech and Language Therapy). Speech and Language Therapy staff have a greater number of discipline-specific targets (589, 33.9%) in comparison to Occupational Therapy staff (462, 26.6%) reflecting the difference in staffing ratio (19 SLT and 12 OT).

While inter-disciplinary work was identified as a common feature of Tier 2, data from the Target Tracker showed that this primarily involved therapist-educator combinations of disciplines, and for Tier 2, the majority of targets were uni-disciplinary (i.e. Occupational Therapist targets or Speech and Language Therapy targets) rather than combined.

ELCs: the majority of targets set by January 2019 (233, 60.5%) were joint Speech and Language Therapy and Occupational Therapy targets in comparison to discipline-specific targets (152, 39.5%). However, by July 2019, a greater number of discipline-specific targets (477, 53.2%) had been set than joint Speech and Language Therapy and Occupational Therapy targets (419, 46.7%). A further one target was not assigned responsibility (0.1%) to any specific discipline(s).

Primary Schools: the majority of targets set by January 2019 (173, 52.9%) were discipline-specific targets in comparison to joint Speech and Language Therapy and Occupational Therapy targets (154, 47.1%). By July 2019, this trend was more evident with an even greater focus on discipline-specific targets (473, 70.8%) than joint Speech and Language Therapy and Occupational Therapy targets (195, 29.2%).

Post-Primary Schools: the majority of targets set by January 2019 (45, 65.2%) were joint Speech and Language Therapy and Occupational Therapy targets. However, by July 2019, a greater number of discipline-specific targets (60, 55.1%) had been set than joint targets (49, 44.9%).

Special Schools: the majority of targets set by January 2019 (18, 54.5%) were joint Speech and Language Therapy and Occupational Therapy targets. However, by July 2019, a greater number of discipline-specific targets (41, 66.1%) had been set than joint targets (21, 33.9%).

5.6.5 Summary

- A bespoke model of recruitment leveraging established practices within the HSE supported the successful recruitment of a team of skilled, experienced Speech and Language Therapists and Occupational Therapists.
- Efforts by the Demonstration Project Management Team and individual therapists ensured that staff at participant schools and ELCs increased their awareness and understanding of the nature of tiered service delivery during the early phases of their engagement.
- The establishment of collaborative project teams in the majority of sites provided an operational platform for the assessment of need and delivery of services at participating settings.

- By the end of the project implementation, the team had successfully implemented a new tiered model of therapy service provision to 150 educational settings across a diverse range of urban and rural settings, and including ELC, primary, secondary and special schools. This is an ambitious scale which required phased implementation and careful planning and monitoring.
- Due to the phased approach of introduction, Tier 1 is the most developed aspect of the project, and is the most prevalent approach implemented across most sites. The long-term goal of a tiered model is to have established a strong Tier 1 as the first important foundation.
- While the phased approach resulted in a short timeframe overall for evaluating the model as a holistic approach, there was emerging evidence of the interaction between tiers and a broadening of ways of practice so that therapists are able to be more effective in working in a school context, and so that educators have ongoing therapy support that is more attuned to their needs and the needs of the child, and therefore provides a service that is beginning to provide the right support at the right time.
- In evaluating the fidelity to the model at each tier, there is emerging evidence of an education-focused, coaching and capacity building approach that is in tune with international evidence and with the NCSE goals for the Demonstration Project.

5.7 Summary

The findings presented above represent a thorough and exhaustive interrogation of a broad range of available data including survey and interview data alongside process data and recorded evidence by way of case-notes and files. The breadth of data presented provides an insight into the task that faced the Demonstration Project to develop, implement and monitor a model of tiered service delivery of therapy services directly to schools and ELCs.

The findings point to a project that established a governance and management model that supported the rapid recruitment and induction of a team of highly experienced Speech and Language and Occupational Therapists. Furthermore, the findings indicate a project leadership that made pragmatic decisions to ensure that (i) supervisory and management functions were in place from the outset, (ii) there was a mechanism for engaging participant locations and a complement of resources to support this and (iii) a tiered model of service delivery could be implemented while ensuring that all stakeholders developed a full and thorough understanding of the composition and nature of the service. The Demonstration Project team was also charged with developing and implementing operational procedures to support the implementation of a novel therapy-service model. This required that they establish clinical supervision, data recording and storage mechanisms and reporting procedures. The consequence of developing such systems in a very short period of time is often that unanticipated consequences can emerge during their subsequent implementation. As would be expected, this did transpire with issues reported including challenges with quickly recruiting and backfilling vacant posts, access to and governance of data recorded and a perceived lack of clarity in supervisory and management processes.

Evaluation of fidelity to the tiered model required triangulation across a broad range of data sources. From ongoing Target Tracker analysis, it was clear that many aspects of a tiered model were actively implemented, which included new ways of working for therapists, such as on-site coaching or modelling of strategies for capacity-building. It was less clear from the targets listed as to what exactly these categories of interventions were referring to. Further analysis of the pre-defined types of targets provided more insight, by comparing Target Tracker and chart data. For example, where whole-school CPD (Tier 1) was listed, frequently therapists were in fact providing an information talk about the Demonstration Project. In other cases, they were providing a CPD talk on key interventions such as child language or motor development. The former CPD event would be more accurately considered part of the school engagement phase rather than a Tier 1 intervention. However, in the Demonstration Project, there were examples documented in charts of the therapists following up on the CPD events by supporting educators to implement their new knowledge, to ensure the CPD training is maximised. This is noted as an essential requirement for good outcomes in school-based therapy provision, according to the literature (Ebbels et al., 2019; Camden et al., 2015). So while the tracker data can be reported in terms of targets and numbers of goals achieved, it is also important to evaluate how these goals were achieved and how they aligned as a cohesive approach in order to determine fidelity to the tiered model.

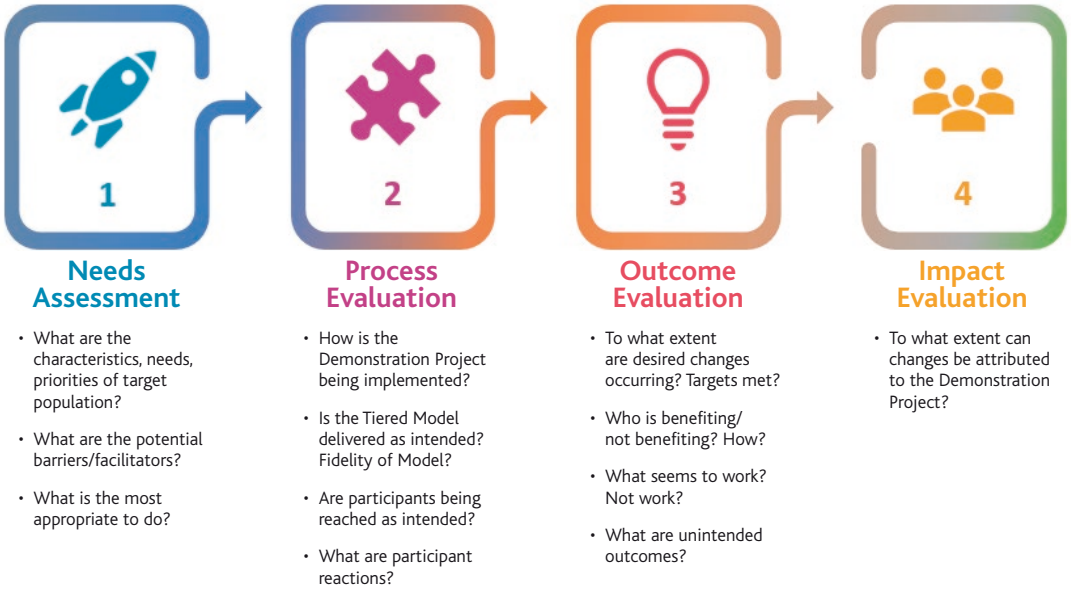
The evidence of more traditional approaches (such as delivering a CPD session on language or sensory regulation) reflects a need to develop more informed education and training for the therapists.

6. Impact Findings

6.1 Evaluation of Impact

From the outset, the key aims of the Demonstration Project were (i) develop greater links between educational and therapy supports, (ii) provide for in-school therapy services within a model of tiered support, and also (iii) provide professional support, training and guidance for school staff and parents. The overall goal was to assist schools to develop their capacity to support children with Speech and Language Therapy and Occupational Therapy needs, while also focusing on early identification and intervention. According to the NCSE Request for Tender, the evaluation was required to examine the impact of the project in a number of ways, including child/student outcomes, capacity building at school and class level, inter-professional and inter-agency working and fidelity to the model of service delivery (see figure 6.1).

Figure 6.1: Evaluation Process for the Demonstration Project



This section of the evaluation report concentrates on the impact of the Demonstration Project to (i) determine what has been effective, (ii) how it has been effective in achieving the goals mentioned above, and (iii) analyse the barriers and enablers in doing so. The first part of this section will present a summary of findings relating to impact from multiple perspectives. The second part of the section will then present further, detailed findings relating to the case study sites visited during this evaluation from the four sectors of pre-school, primary school, secondary school and special schools. The data sources for this aspect of the evaluation are outlined in Table 6.1 below.

Table 6.1: Data Sources for Evaluating Outcomes and Impact

Educators scoping surveys[61]	World Café interviews with educators	Therapists interviews	Therapy scoping surveys	Case studies: Parent interviews	Case studies: Teacher interview	Case studies: Child interview	Target Tracker	Stakeholder Interview

6.1.1 Context of the Demonstration Project

Given the evidence presented in Sections 5, it is possible to state that all 150 sites had been involved to a greater or lesser extent in this Demonstration Project and that therefore there is a potential impact on the children and educators in those sites. From the documentary analysis, Table 6.2 below outlines the numbers known to the evaluation team:

Table 6.2: Profile of Student and Educational Staff Numbers According to Setting Type[62]

Type of setting	Total number of sites	Child/student numbers	Education staff numbers	Special needs assistant numbers
ELC	75[63]	1,742 (23 sites did not provide this information)	Data missing for staffing numbers for all 75 sites	Data missing for staffing numbers for all 75 sites
Primary school	54	15,708	Not known (not documented in database of sites nor in chart files nor in school profile data)	286 for 626 students listed as needing SNA support
Post-primary school	15	9,705 (data missing for 3 schools)	Not known (not documented in database of sites nor in chart files nor in school profile data)	64 SNAs for 131 students listed as needing SNA support
Special school	6	523	76	117 SNAs

61 See Appendix F for an overview of the survey respondents' profiles.

62 Based on data from the NCSE 150 site spreadsheet shared with the evaluation team. It is important to note that the numbers for educators and children in each setting varies across data sources, so these numbers need to be considered as an estimate of actual figures.

63 Although 74 was the final number by summer 2019.

Table 6.2 above demonstrates the breadth of the project, whereby approximately 31 therapists[64] were covering a workload[65] of 150 sites, with more than 27,678 children and their educators and caregivers from these sites, including SNAs, managers and principals. It should also be noted that the full complement of 31 therapists was not always in place for the duration of the project. While there is no central profile of the numbers of children with special needs, Occupational Therapy needs or Speech and Language Therapy needs, the survey data provided some insight. Survey responses from managers and principals indicate that approximately ***ten percent of children*** in their sites had needs that they perceived could be addressed by the provision of the Demonstration Project therapy on-site. Yet, a majority (91%) of these settings did not have on-site access to such therapy services outside of the Demonstration Project.

6.1.2 Impact Concerning Implementing a Tiered Therapy Model in an Irish Context

When surveyed about the factors that had facilitated their implementation of tiered model, educators referred to: (i) the therapists' knowledge and responsiveness, (ii) team-working amongst staff, (iii) linkages with parents, (iv) good communication, (v) regular meetings and teachers' willingness. When asked about any barriers to the implementation of a tiered model, educators identified: (i) the lack of time they had to devote to the project, (ii) the time needed to get the project underway, (iii) limitations on staff input and (iv) non-participation by some of their colleagues. This mirrors feedback gathered when visiting primary schools where principals (n=2/7) highlighted the challenges of accommodating meetings and planned work with the project. Despite educators identifying that the Demonstration Project was a positive addition to their work, they also spoke about the increased 'workload' because of their settings participation in the Demonstration Project. In particular, educators identified that they have to do *'a lot of after-work activities'* that include meetings with project therapists and participating in evaluation activities for the Demonstration Project. Educators also reported that overall, through involvement in this new way of working, staff had acquired new understanding and greater awareness, and had gained new insights as a result of their engagements with the therapists.

6.1.3 Impact Concerning Capacity Building Amongst Educators

Data shows that overall, educators felt very positive in terms of being involved in the project, and appreciated the professional support being given from the therapists. From the World Café, educators particularly noted that the project therapists had provided them with a lot of *'resources and ideas'* and highlighted the value of in-class modelling provided by the project therapists. The educators emphasised the success of the strategies modelled by the project therapists and the resources that the project therapists had shared with them as a means to better facilitate the engagement of children in their settings.

64 The therapy staffing varied across the year as some staff left leading to the need for further recruitment.

65 See workload versus caseload, Workload model statement jointly developed by the American Occupational therapy Association and the Speech, Language, Hearing Association, accessed https://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf.

During the Demonstration Project, there was a growing awareness on the part of educators as to how therapy services to schools would impact their work. Engagement with therapists throughout the project, it would appear, increased the knowledge and understanding educators held as to the function and role of Speech and Language and Occupational Therapists in school-based practice. Initially, educators reported that they did not fully understand therapy roles. At a later phase of evaluation, in contrast to the early stages of the project, one educator noted that *'I now know what to ask when the therapist comes in'* pointing to the fact that they now had greater awareness of what a project therapist could offer and as such could formulate targeted questions that address educational outcomes. Furthermore, educators in one primary school noted that the project therapists developed 'drop-in clinics' whereby the *'teachers could go and spend five minutes each with [the project therapists] and ask questions'*.

The impact on educators' practice was also evident in their response to the supports and resources that they received through the Demonstration Project. Educators' surveys noted that despite not having one-to-one support in their setting at this stage, that such an opportunity offered them space to *'ask questions about individual children'* to try to facilitate change and support both educators and children in the school environment. For example, they noted that *'the calming cards provided by the OT were going to be laminated and displayed in all classrooms'*. They further pointed out that this *'would even support substitute teachers to know what is happening in the school'*. From these examples, it is clear that although weekly attendance was not possible, the regularity of contact with educators and the knowledge that they were available to the educators was a significant factor in outcomes related to capacity-building.

A further anticipated impact for educators was how CPD efforts by therapists in individual settings built capacity amongst educators. From the therapy surveys, almost all (n=21/27) perceived that the project has realised its aims in respect of building capacity within schools and ELCs. Data from the educators' survey added further evidence of outcomes about their experiences of receiving support and guidance when the questionnaire invited respondents to make an overall assessment of their experiences of the Demonstration Project. The following bar graph (Figure 6.2) presents their cumulative responses in respect of particular dimensions of the project.

Figure 6.2: Educators' Overall Assessment of the Demonstration Project, from all Four Settings, in Respect of Particular Dimensions and the Extent to which these were Realised (n=83)

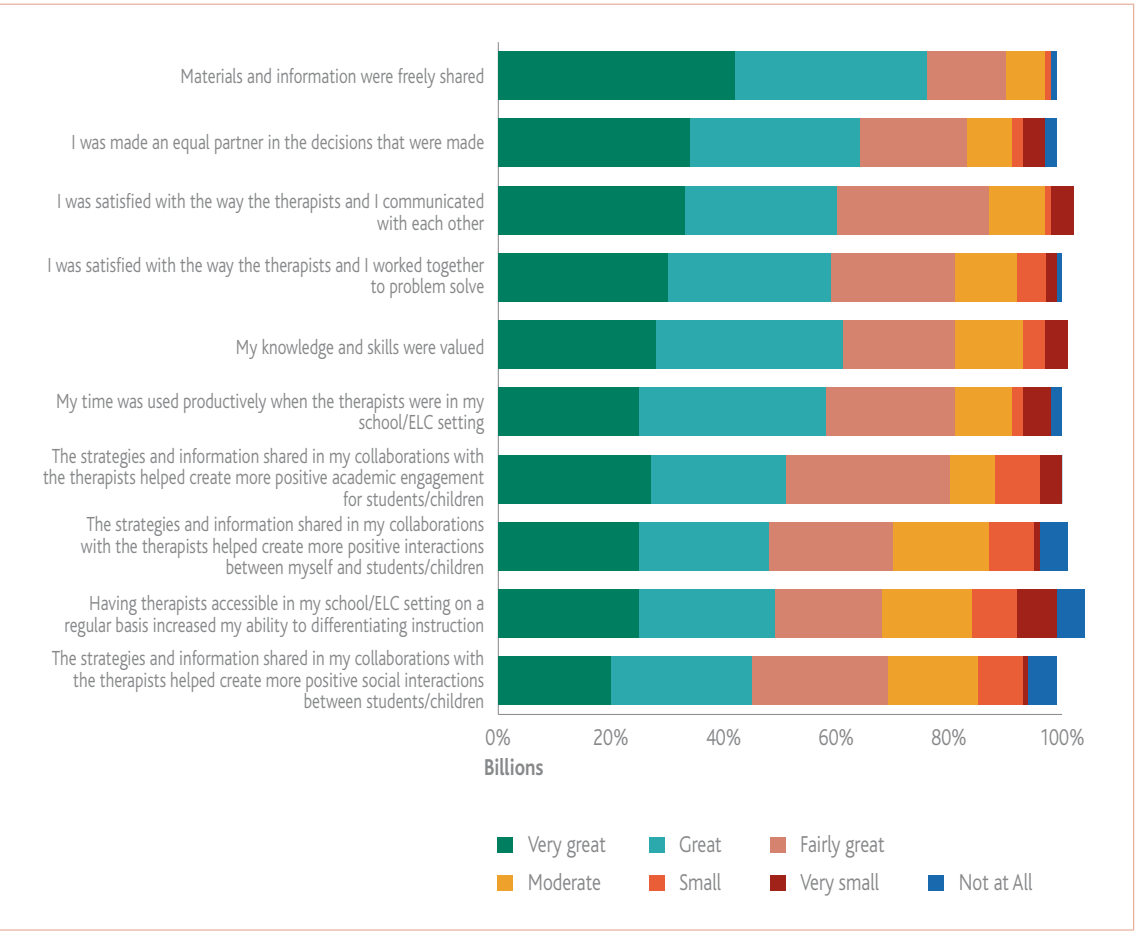


Figure 6.2 illustrates that in a majority of cases, particular practices and approaches (as listed here) were realised to a 'very great', 'great', or 'fairly great' extent. The practices with the most significant application were 'Materials and information were freely shared' (90% to a very great, great or fairly great extent) and 'I was made an equal partner in the decisions that were made' (83%).

Figure 6.2 also presents a positive response with regard to key inclusion criteria including contributions to positive social interactions between children, and positive teacher-student interactions. Data also demonstrates a perceived increase in ability to deliver differentiated instruction on the part of respondents. Further interview data gathered during setting visits highlighted a desire for the evaluation team to highlight their satisfaction with the Demonstration Project, noting that their participation in the Demonstration Project was a *'very positive experience on the whole'*. All participants agreed that the Demonstration Project was *'definitely a step in the right direction'* in terms of providing therapy in context.

An area of impact worth noting from this evaluation is the effect that participation in the Demonstration Project had on increasing educators' confidence in their own abilities and expertise. As one ELC manager interviewed pointed out, staff at her setting had *'increased confidence in identifying struggling children'* because of the *'mentorship and training'* received as part of the Demonstration Project. They noted that you *'can be sure of your thinking, can do more'* and are *'supported by project therapists'*. Moreover, teachers interviewed in a participating primary school noted that the Demonstration Project offers an opportunity to 'pick up on' issues such as speech and language issues that typically do not *'come on the radar until primary school'* and having project therapists in-situ offers an opening to *'flag children on the spot'*. Survey and World Café data noted that for the most part, ELC educators perceive that they are *'not taken seriously'* when they highlight issues like the aforementioned. They noted that the presence of project therapists facilitates external *'support and validation'* for their hypotheses, and this in turn *'backs up educators when they highlight concerns with parents'*.

6.1.4 Impact Concerning Children

An inherent challenge in determining impact for children in receipt of therapy using a tiered approach, as was the case in the Demonstration Project, is that much of the capacity-building, changes to practice and many Tier 1 interventions aim to create systemic change rather than change at the level of the child. However, educators were explicitly asked to comment on outcomes for children that could be attributed to the efforts of the Demonstration Project.

Data gathered and analysed in this evaluation confirmed that it was indeed too early to point to specific changes anticipated, but that the efforts demonstrated a move in the right direction. From the educators' surveys (n=83), just over half of all respondents reported that the Demonstration Project had promoted capacity and inclusion in their settings/schools. During the educator's World Café, all participants (n=17) noted that while they *'personally think it is working'*, it was still too early to identify outcomes from the Demonstration Project, stating *'I will know more next year'*. Given that the Demonstration Project was still in the relatively early stages of implementation, educators and relevant support staff felt that it was too early to identify outcomes for children, emphasising the time required to build mutual understanding of the needs of classes and specific children.

There were however, some indicators of impact on children's engagement highlighted by, when asked in the educators' survey about the outcomes for children, staff and their settings overall, educators reported that children have acquired increased confidence and improved listening skills. From the therapy surveys, almost all (n=21/27) perceived that the project has realised its aims in respect of building capacity in respect of supporting students' learning and engagement.

Finally, the survey data from the educators revealed that educators felt that the strategies shared by therapists helped to engage the students and create more positive interactions, and that having access to the therapists helped them to differentiate their instruction.

6.1.5 Impact Concerning Professional Support, Training and Guidance for Parents

The delivery of therapy services directly to schools impacted how the need for and provision of such services was perceived by parents in particular. Reports emerged during the evaluation of the ease at which services provided at school/ELC could be accessed, how traditional associations of stigma could be minimised and how the involvement of parents and/or guardians could be improved. Participants at the World Café noted that having project therapists in school/ELC settings offers *'support to not only children but parents also'*. They pointed out that the traditional *'clinic can be daunting for parents and children'* because clinic-based settings make them feel like *'something is wrong'*. Participants noted that providing supports *'in children's natural environments removes the fear factor'* associated with clinic-based settings. They said that the parents are *'loving the whole-school approach'* because *'kids are not being singled out'*, highlighting the inclusive nature of the Demonstration Project. In addition, one participant noted that the project therapists inform parents that they are collaborating with ELC educators. While this participant indicated that before the Demonstration Project, they felt *'not important in the eyes of parents'*, they noted that this collaborative approach has increased parents' confidence in their knowledge and skills. Also, they noted that the project therapists have facilitated greater parental involvement in their setting, stating that *'I now feel like I know the parents better'*. Nonetheless, participants from one primary school noted that they had not *'really involved parents'* as part of the Demonstration Project but indicated that *'parents would really enjoy being involved'*.

6.1.6 Impact Concerning Inter-Professional and Inter-Sectoral Working

A strong theme emerging from this evaluation was with regard to the impact of the Demonstration Project in promoting and providing ongoing support for changes in collaborative work practices between education and health professionals.

From interview data gathered during site visits, educators noted an increase in collaborative practices *'as time goes on'* in the project. They noted that in the early stages of the project, it was *'more about what the project therapists wanted to do'* which consisted of *'meetings in the office'*. However, the educators noted that after this consultation phase, project therapists are *'now in the class/room and are playing with children'*. One participant from an ELC setting noted that *'for example, yesterday we had the Speech and Language Therapist visit and they were on the floor with the children playing and building, it was great'*. This increased collaboration points to the time required for relationship building in a project like that envisioned here, which is what is evident in the literature.[66] When asked specifically about how long it took to develop a relationship of mutual trust and respect with project therapists' educators noted that it had taken *'a third of the time'* with some participants noting that it had taken *'until Christmas'* suggesting that it took almost half of the school year. These findings mirror the experiences reported from other international exemplars of practice: experiences of establishing tiered-model services in other jurisdictions highlight the time needed to build relationships.[67]

66 As noted in Section 3, 3.2.1.

67 See discussion regarding implementation of P4C in Canada in Section 2 and 3 of this report. Also, Wilson and Harris (2018).

There was further evidence of an increased recognition of the importance of relationships and the requirements to dedicate time and resources to such relationships in order to ensure ongoing success. Although the time available limited the full development of these new working relations, the evaluation highlights the work done and the potential that the Demonstration Project has to impact the relationships between health and education personnel into the future.

Therapists survey data confirmed that a majority of respondents perceived that there was insufficient time to develop relationships during this first year of the project. However, interviews with representatives from the inter-sectoral group noted the huge potential of the project for joint working, but were disappointed to note that this was slow to happen on the ground, Much of the difficulty was attributed to challenges defining the projects therapists' role at Tier 3, poor communication and a lack of clarity around the roles and responsibility of each profession.

6.2 Impact Evaluation: Perspectives of Demonstration Project from Case Study Settings

For this part of Section 6, the evaluation moves towards focusing on impact by presenting detailed evidence from the 20 Case Study sites that formed a core part of the evaluation. The data is drawn from the case study visits, alongside World Café and focus-group feedback and interviews. The data is presented across the four main types of settings: a) ELCs, b) primary schools, c) post-primary schools and d) special schools (see Table 6.3).

Table 6.3: Data Source List for the 20 Sample Sites

Code	Principal/ Manager Interview	World Café[68]	Setting visit and observation: Staff involvement	Setting visit and observation: Child involvement	Setting visit and observation: Parent Involvement
ELC A	√	2	3 staff	6 children	2 parent interviews
ELC B	√		3 staff	7 children	3 parent interviews
ELC C	√	2	4 staff	5 children	5 parent interviews
ELC D	√	1	3 Staff	8 children Drawings and focus group	2 parent interviews
ELC E	√		1 staff	No	No
ELC F	√		1 staff	No	No
ELC G	√		1 staff	8 children drawings and focus group	No[69]
ELC H	√	1	4 staff	5 children drawings and focus group	1 parent interview

68 Numbers in this column indicate the numbers of staff from each of the locations that attended the World Café.

69 Parents' consent forms not returned by the close of the evaluation.

Code	Principal/ Manager Interview	World Café[68]	Setting visit and observation: Staff involvement	Setting visit and observation: Child involvement	Setting visit and observation: Parent Involvement
PS A	√		2 staff	8 children focus group	No parental consent received
PS B	√	2	6 staff	6 children focus group	4 Parents interviews
PS C	√		2 staff	No	No
PS D	√		2 staff	1 child	1 parent interview
PS E	√		1 staff	No	No
PS F	√	2	4 staff	7 children	3 parent interviews
PS G	√	1	4 staff	No	No
PP A	√		2 staff	No	No
PP B	√	2	2 staff	6 children	3 parents interviews
PP C	√		1 staff	No	No
SS A	√	2	4 staff	5 children	No
SS B	√	1	5 staff	5 children	2 Parents interviews
Totals	**20**	**16**	**55**	**77**	**26**

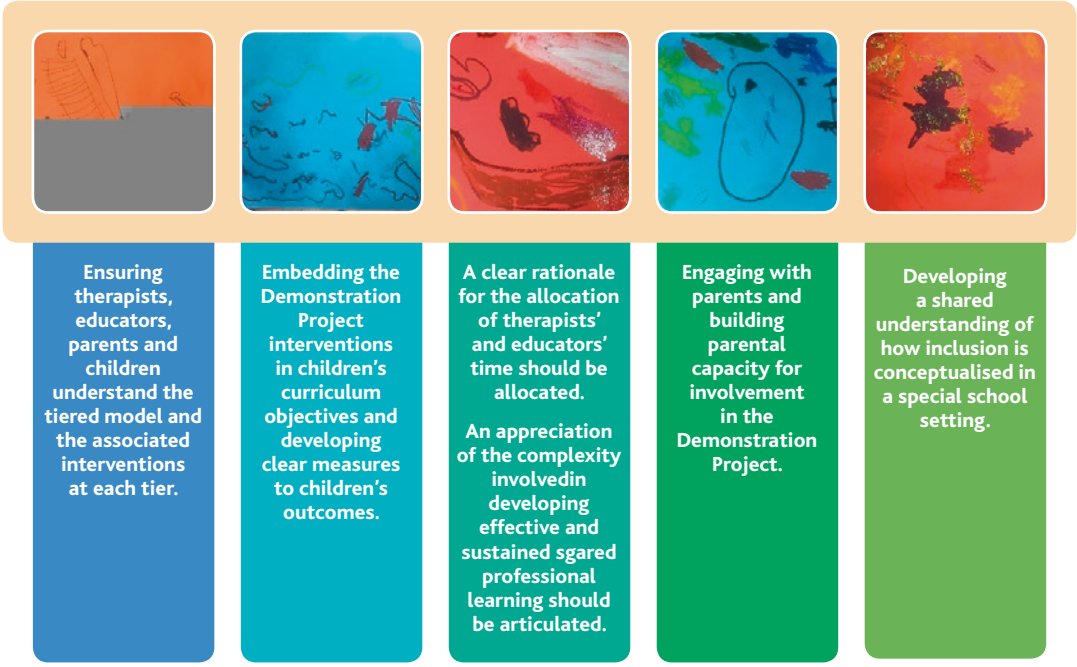
The following section presents some findings from the focused case study sites which were all engaged in visits from the evaluation team, and also took part in World Café and interviews, for more detailed data collection. The data here is presented to give personal insights from the coalface.[70]

6.2.1 Impact and Outcomes as Experienced in Early Learning and Care Setting

From data synthesis across the varied data sources from ELC settings, figure 6.3 identifies components of what the ELC stakeholders found to be effective in their experiences of the Demonstration Project to date.

70 Data relating to target tracker and surveys are already presented in Sections 5, 6 and 7 so are not repeated here, to avoid duplication and maximise clarity.

Figure 6.3: Key Components for Effective Therapy Provision in an ELC Context



In reporting the findings in this chapter, data sources are coded with reference to the codes identified in Table 6.4

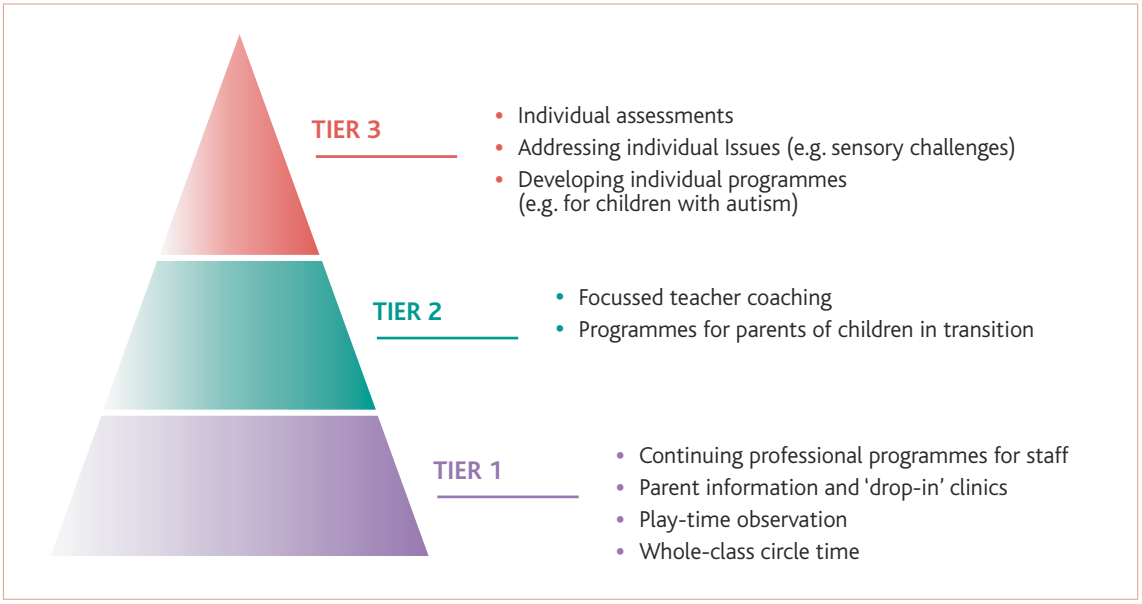
Table 6.4: Data-Reporting Codes ELC Case Studies

Site	Manager	Practitioner	Parent	Child	SLT	OT
ELCA	ELC_A_M	ELC_A_PR1/2	ELC_A_P1/2	ELC_A_C1/2	ELC_A_SLT	ELC_A_OT
ELCB	ELC_B_M	ELC_B_PR1/2	ELC_B_P1/2	ELC_B_C1/2	ELC_B_SLT	ELC_B_OT
ELCC	ELC_C_M	ELC_C_PR1/2	ELC_C_P1/2	ELC_C_C1/2	ELC_C_SLT	ELC_C_OT
ELCD	ELC_D_M	ELC_D_PR1/2	ELC_D_P1/2	ELC_D_C1/2	ELC_D_SLT	ELC_D_OT
ELCE	ELC_E_M	ELC_E_PR1/2	ELC_E_P1/2	ELC_E_C1/2	ELC_E_SLT	ELC_E_OT
ELCF	ELC_F_M	ELC_F_PR1/2	ELC_F_P1/2	ELC_F_C1/2	ELC_F_SLT	ELC_F_OT
ELCG	ELC_G_M	ELC_G_PR1/2	ELC_G_P1/2	ELC_G_C1/2	ELC_G_SLT	ELC_G_OT
ELCH	ELC_H_M	ELC_H_PR1/2	ELC_H_P1/2	ELC_G_C1/2	ELC_H_SLT	ELC_H_OT

ELC managers and practitioners reported, *"huge feelings of positivity for the project"* (ELCB_M). Parents also welcomed the Demonstration Project, ELCC_P1 noted being *"surprised something so innovative was happening and readily accessible"*. The significance of early intervention was noted by ELC participants and the inclusion of children less than three years old was seen as a particular strength of the Demonstration Project given that supports such as those available in the Access and Inclusion Model (AIM) are only available for children who are participating in the Early

Childhood Care and Education (ECCE) Programme. Parents had similar views: "younger children are more malleable and it is great to have the support available" (ELCC_ P2). Figure 6.4 includes exemplars of interventions implemented in each of the Tiers in ELC settings.

Figure 6.4: Exemplar Interventions Implemented at Each Tier in ELC Settings



ELC staff emphasised the benefits of therapists working with them as part of capacity building (ELCC_PR3). Highlighting the enthusiasm by which capacity building efforts were received by ELCs participating in the Demonstration Project, therapists acknowledged how receptive ELC settings have been from the earliest stages of engagement (World Café SLT/OT).

Staff at participating ELCs were positive about collaboratively working with therapists and emphasised that they felt *"listened to"* (ELCC_PR3) and that *"therapists were sensitive to the needs of staff"* (ELCG_M). ELC teams expressed the value they placed on the conversations and interactions that they had with therapists serving their setting. They highlighted the fact that therapists looked for and valued their reports of their observations of children and *"treated us like professionals, as if we are their peers"* (ELCG_M). The value of Tier 1 and 2 interventions was highlighted with ELC educators welcoming ideas which supported them using the outdoor environment, games, small-group time and circle time to support aspects of development such as self-regulation. Participants interviewed highlighted how their existing practices had improved through the incorporation of such interventions: *"using circle time, a lot, to support children using their voice – all children are now speaking in their high, middle and low voices"* (ELCE_M).

The value of talking to therapists about children they had concerns about was highlighted by some of those interviewed: "we thought we had six children with speech and language problems. We were surprised the SLT informed us only two of these children had problems" (ELCB_M). Furthermore, ELC management stressed the importance of such collaborative practices informing Tier 3 interventions could inform more efficient service delivery for children and families: "that was immediately four children off the waiting list for SLT" (ELCB_M).

The coaching aspect of the project was particularly commended and involved therapists modelling strategies, observing staff using strategies and providing feedback. ELC staff felt that the Demonstration Project extended their repertoire of practice skills, for example, understanding how to balance their communications with children and working in smaller, more focused groups.

The value of the resources provided was also highlighted: "the Occupational Therapist gave a resource, a circle with lots of different activities like hopping and skipping to strengthen core muscles" (ECB_M). Similarly, staff expressed the value of the continuing professional learning opportunities provided during the project such as the Hanen and Lámh programmes.

Figure 6.5: Developing Through Play in the ELC Context: ELCA_C1
"Everything I Love about Pre-School"



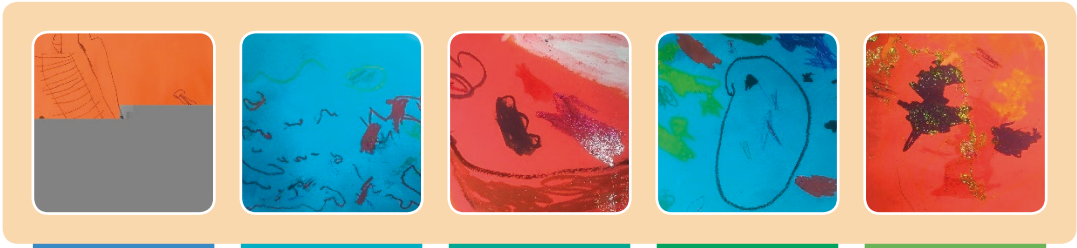
Interviews with ELC staff at participant settings demonstrated additional value that can be achieved through active, engaged teamwork. It was reported that in some circumstances, therapists provided important back-up to ELC staff where parents seemed *"more willing to listen to somebody other than the early years educator"* (ELCF_M). Many novel approaches were used to encourage parental involvement in the Demonstration Project with 'drop-in' times scheduled around the day-to-day operations of the ELC being of particular note. ELC staff interviewed acknowledged that parents, particularly of children with diverse learning abilities, benefited from the additional support provided through the Demonstration Project. Overall, they believed that *"being involved in the project acts as an incentive for collaborating with parents and families"* (ECD_M). Supporting parents engaging in home learning activities was considered particularly effective e.g. *"I met the Speech and Language Therapist who shared the strategies with me – role play, action words, matching pictures and words, putting words in sentences"* (ELCC_P2) while according to a manager *"it can encourage parents to do work at home"* (ELCB_M). One mum engaged for two weeks and there was a noticeable change in her child's language then the engagement dropped off again *"but we keep reminding them to talk, to use new words at home"* (ELCB_M).

While there were initial concerns expressed that the intervention activities may not align with the child-centred, emergent, playful pedagogical approach articulated in *Aistear* (NCCA 2009) and *Síolta* (CECDE 2006), this concern appeared to dissipate during the year. Furthermore, ELCs agreed that being involved in the Demonstration Project *"helps to make the service more inclusive"* (ELCH_M). The post-project survey data found that 87% of these ELC respondents believed that the Demonstration Project promoted capacity and inclusion in their setting. The Demonstration Project was valued in terms of its capacity to consolidate collaboration with other services such as the HSE and primary schools.

6.2.2 Impact and Outcomes as Experienced in Primary Schools

From data synthesis across the varied data sources from primary school settings, Figure 6.6 identifies components of what the stakeholders found to be effective in their experiences of the Demonstration Project to date.

Figure 6.6: Key Components for Effective Therapy Provision in a Primary School Context



Building and delivering a CPD programme that matches the expressed needs of the school. Establishing a collaborative understanding of the range of services available.	Greater alignment between Demonstration Project interventions and regular curricular activities. Differentiation to meet the needs and interests of all children.	Establish clarity as to the role of the teacher and other school-based staff, identifying scope of responsibilities and exploring how the role of 'teacher' can be supported.	Buildng parental capacity for involvement in the Demonstration Project. Develop a training and capacity building programme for parents in the project. Consider delivering this in partnership with teaching staff.	Provide project therapists with a curriculum support resource within the team. Consider appointing a teacher or teachers to the delivery team with a view to supporting the embedding of interventions within curriculum demands.

In reporting the findings in this chapter, data sources are coded with reference to the codes identified in Table 6.5.

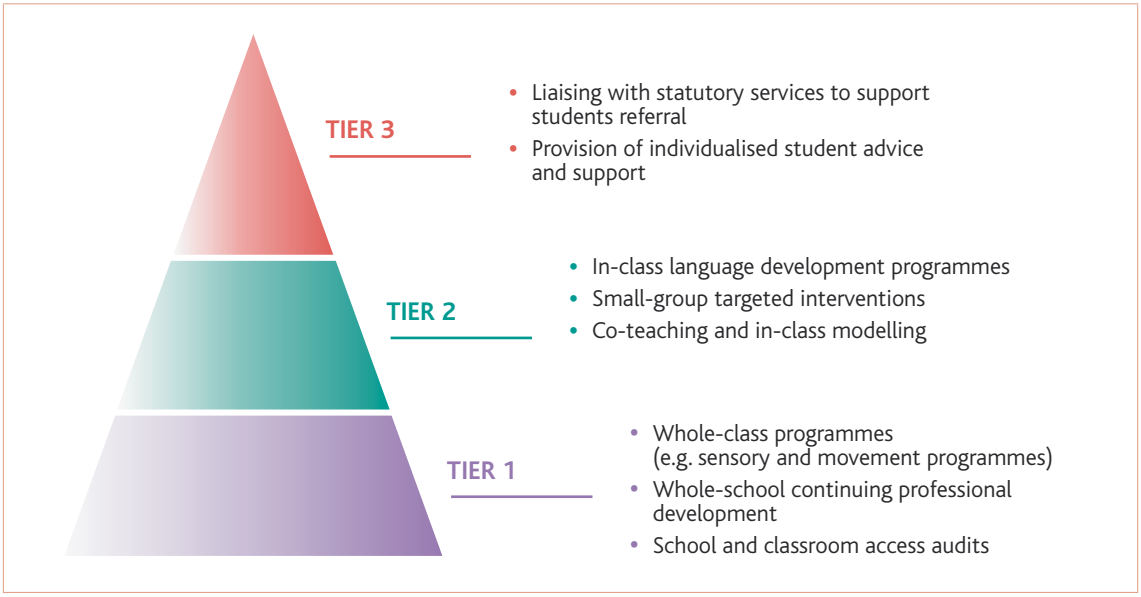
Table 6.5: Primary School (PS) Settings: Case Study Data

Site	Principal	Teacher/ School Staff	Parents	Child	SLT	OT
PSA	PS_A_P	PS_A_PR1/2	PS_A_P1/2	PS_A_C1/2	PS_A_SLT	PS_A_OT
PSB	PS_B_P	PS_B_PR1/2	PS_B_P1/2	PS_B_C1/2	PS_B_SLT	PS_B_OT
PSC	PS_C_P	PS_C_PR1/2	PS_C_P1/2	PS_C_C1/2	PS_C_SLT	PS_C_OT
PSD	PS_D_P	PS_D_PR1/2	PS_D_P1/2	PS_D_C1/2	PS_D_SLT	PS_D_OT
PSE	PS_E_P	PS_E_PR1/2	PS_E_P1/2	PS_E_C1/2	PS_E_SLT	PS_E_OT
PSF	PS_F_P	PS_F_PR1/2	PS_F_P1/2	PS_F_C1/2	PS_F_SLT	PS_F_OT
PG	PS_G_P	PS_G_PR1/2	PS_G_P1/2	PS_G_C1/2	PS_G_SLT	PS_G_OT

The importance of extensive preparatory work through provision of resources and materials that could be readily implemented emerged as a factor in ensuring successful implementation of tiered service delivery in Primary Schools.

Principals interviewed expressed satisfaction with the materials and the kind of information that was made available initially, resulting in an understanding of the goal and the purpose of the tiered model. The provision of such materials ensured that school leadership and the wider teaching team were clear as to the objectives of the Demonstration Project, and established an understanding of the tiered delivery of therapy services. There was a clear commitment to ensuring that developing a shared understanding of this new approach to service delivery was adhered to throughout the year. While some staff interviewed spoke of their initial expectations of their participation making in-school 1:1 intervention available in schools, by the end of the school year they expressed a clear understanding of the benefits of and rationale for a tiered approach; *"in our enthusiasm to get services for those children who really struggle we thought, perfect, we'll have a Speech Therapist available here, job done"*. This teacher continued; *"we took a little convincing, but they [assigned Project therapists] really did a good job of getting us to ask some hard questions of ourselves, that's where the CPD programme came from, and that's what put us all on the one page..."* (PS_C_PR1).

Figure 6.7: Exemplar Interventions Implemented at Each Tier in Primary School Settings



Discussions with teachers during primary school site visits further highlighted their evolving understanding of the types of support or interventions that comprised the tiered model; *"it took us a long time to work out what we could do, there was no menu or anything"* and how the project offered opportunities to share experiences with other schools to further their own school's development; *"when myself and the Deputy Principal went to the management meeting with the project ... we started to see what other schools were doing and that gave us lots to think about on the way home, it was all we could speak about at the next staff meeting"*. There was evidence as well that communicating the broader benefits of tiered service delivery and embedding these in schools contributed to the overall success of the Demonstration Project implementation in Primary Schools.

This emerging understanding of the value of delivering services in a tiered manner became apparent to teachers and school staff as the school year progressed and as their project participation and collaborative practice matured amongst project teams. Staff interviewed spoke about in-class modelling by the therapists that they described as *"fantastic"*(PSF). They also described being in a DEIS Band 1, noting that sometimes families were not sufficiently resourced or had the capacity to access community services and that this project could counteract that. They felt that the project was reaching otherwise hard-to-reach children i.e. due to community waiting lists).

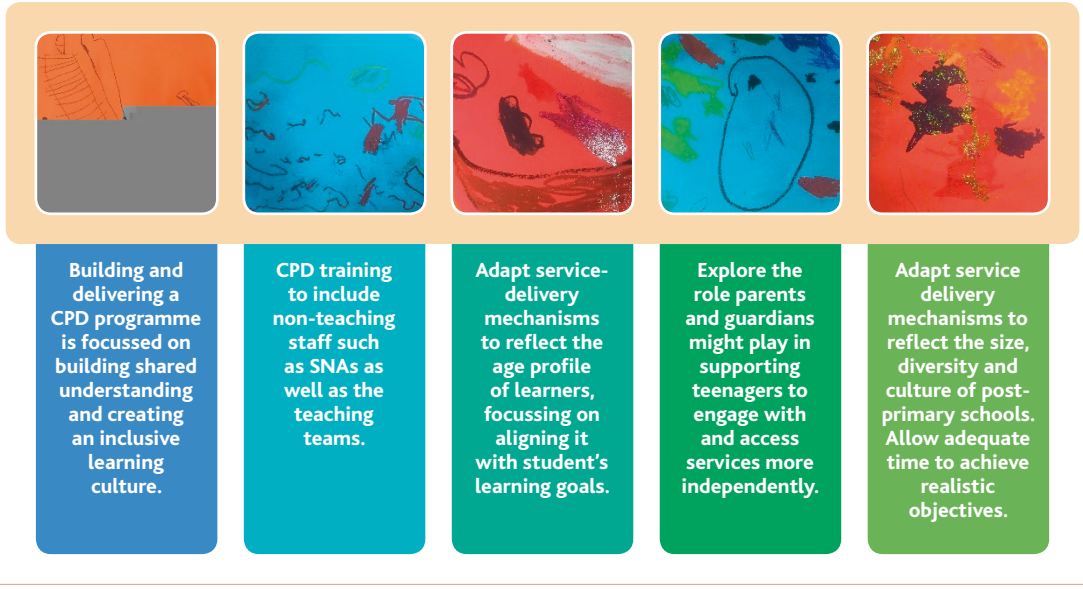
Interviews with parents highlighted a positive regard towards the Demonstration Project and its objectives in this regard. Some parents highlighted their experience of waiting for therapy appointments; *"it would be a better arrangement than having to wait six months to get a therapist in my area, parents just go private"* (PSA_P1). There was a broad welcome for the provision of therapy services in primary schools with a focus in particular on reducing or removing the need to be taking children out of school for appointments; *"you have to remember, there's only so many days they can be off, I would rather that my child is in school than driving through traffic to bring him to his speech therapy"* (PS_B_P3). Generally, parents expressed that their understanding of a tiered model of service delivery was limited but were clear that the outcome of a school's participation was to provide support to all students in accessing the school curriculum; *"I'll welcome anything that makes it easier for children to learn and do the best that they can"* (PS_G_P1). This points to the further potential that could be realised in exploring further mechanisms for integrating families in the implementation of school-based services perhaps through education or CPD programmes tailored to meet their needs.

Many of the children participating in school-based focus groups expressed positive impressions of their participation in the Demonstration Project. They expressed particularly positive sentiments towards the therapists assigned to their setting; *"it's fun when they visit"* (PSC_C1). Participating children did not assign professional designations to the assigned therapists, understanding them not as Speech and Language Therapists or Occupational Therapists but as individuals *"helping us to learn better, make it more fun in our class"* (PSD_C1). In many instances, participating children highlighted the regularity at which therapists visited their school, appearing to express a greater familiarity with those therapists visiting their schools on a weekly or fortnightly basis. A further example of how the work of the Demonstration Project was seen by participating children as a part of their overall learning experience can be seen in how they describe their participation interventions implemented. Unsurprisingly, children associated therapists with the work that they did as part of such interventions. This was particularly the case for Tier 2 interventions where children tended not to describe their own participation. Rather, they described the posters, pictures or other resources that were created or left in the school after the completion of the intervention: *"...it was our idea and we made it all together, but they [Project Therapists] just helped us out..." "we have it [Alert Programme information] on the wall now so we look at it and he [Class Teacher] talks about it, he doesn't forget it anymore"* (PSF_C1)

6.2.3 Impact and Outcomes as Experienced in Post-Primary Schools

This section outlines the findings of the evaluation of the Demonstration Project as they relate to Post-Primary Schools or Secondary School (PPS) settings. The findings are presented with reference to the themes that emerged from the analysis of the data.

Figure 6.8: Key Components for Effective Therapy Provision in a Post-Primary School Context



In reporting the findings in this chapter, data sources are coded with reference to the codes identified in Table 6.6.

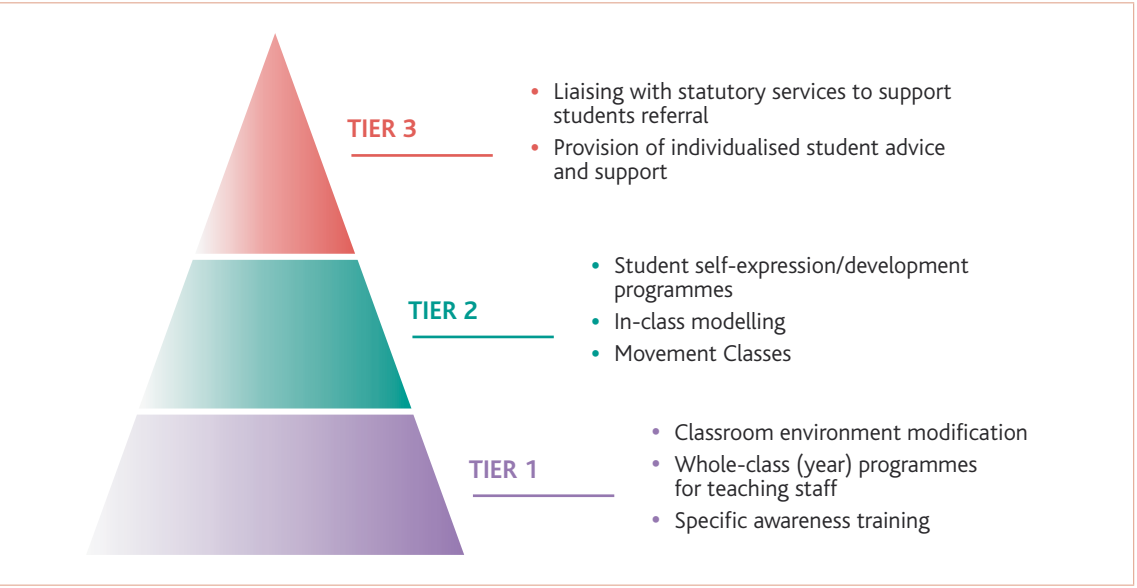
Table 6.6: Post Primary School (PPS) Settings: Case Study Data

Site	Principal	Teacher/ School Staff	Parents	Child	SLT	OT
PSA	PP_A_P	PP_A_T1/2	PP_A_P1/2	PP_A_C1/2	PP_A_SLT	PP_A_OT
PPB	PP_B_P	PP_B_T1/2	PP_B_P1/2	PP_B_C1/2	PP_B_SLT	PP_B_OT
PPC	PP_C_P	PP_C_T1/2	PP_C_P1/2	PP_C_C1/2	PP_C_SLT	PP_C_OT

The review of data gathered pertaining to the implementation of the Demonstration Project across the participating post-primary settings demonstrated the team's understanding and response to some of the unique challenges faced with delivering therapy services to this sector.

During the World Café with project therapists, they noted that progress in secondary schools was slower than in other sectors, reflecting the size, diversity and in many instances, the unique culture of these settings. Discussions with school leadership, with project teams and from site visits suggested a more complex picture of a culture in the post-primary sector that required that the Demonstration Project develop service delivery practices to match these.

Figure 6.9: Exemplar Interventions Implemented at Each Tier in Post-Primary Settings

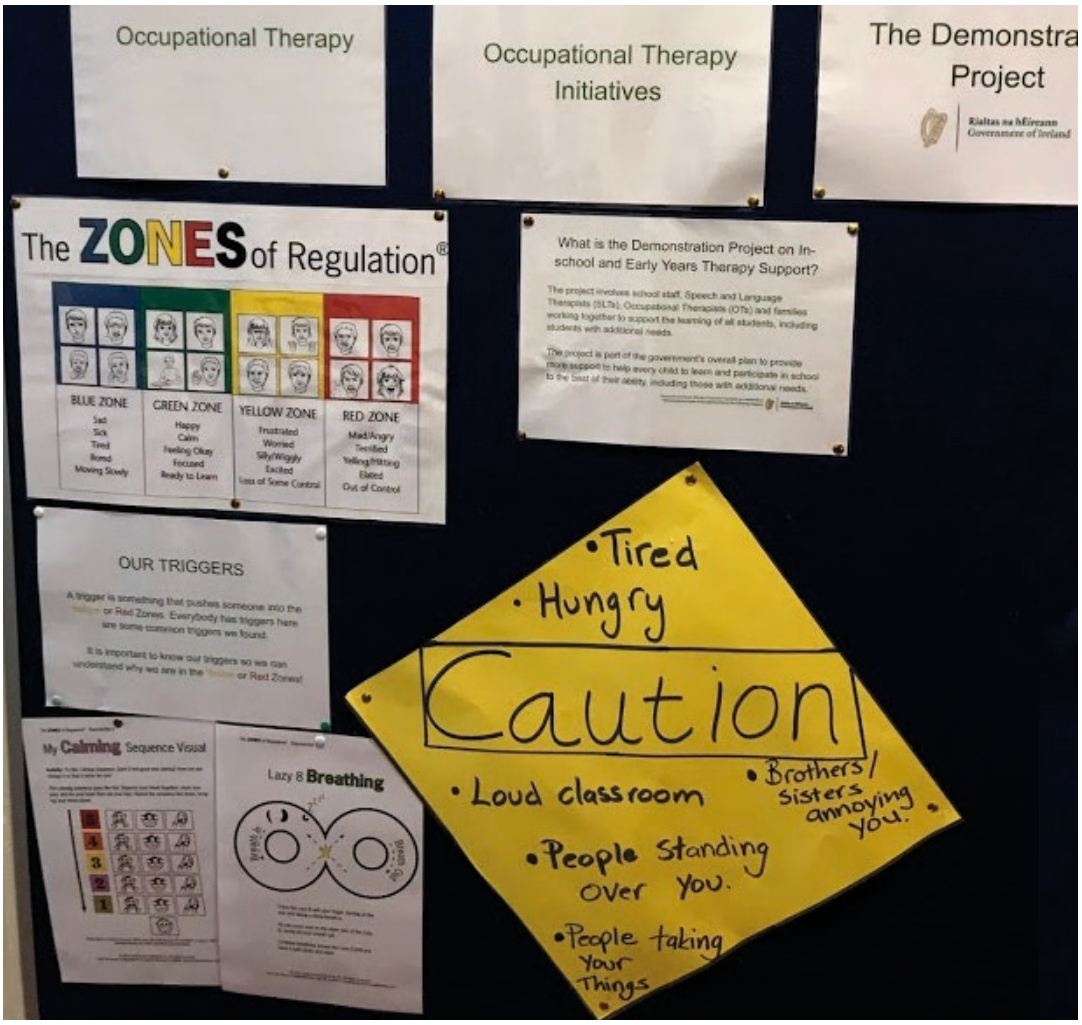


In visits to the sample of three participating secondary schools and from interviews with the school principals, it became evident that second-level schools present a range of distinct challenges in efforts to deliver tiered-model therapy services to students. One school principal remarked that their capacity to participate in the collaborative activities in an initiative such as the Demonstration Project required challenging existing work practices to increase the overall understanding of inclusion in schools. Principals interviewed spoke of *"resistance to change"* and *"adherence to practice"* as barriers for some teachers and observed that "some members of staff just don't want to know" and "as long as they can just do their job they do not want to take on any further additional responsibility". In two of the schools visited, members of the school leadership pointed to a need *"to change the attitudes of the general teaching staff"* and a need to systematically *"change how teaching is delivered and how children are valued"* as challenges to their ability to fully engage with the project objectives.

This may go some of the way in understanding why the emphasis in effort appears skewed towards Tier 1 interventions in post-primary settings. Therapists assigned to these settings reflected during the World Café some of the challenges of building capacity and establishing collaborative working relationships with teaching staff: *"sometimes, it is a matter of just going back with the same CPD, it is impossible to catch everyone that you need on a single visit, so we rely on local coordination to make it work"* (PP_C_SLT).

In seeking to address these challenges there was evidence of flexibility and adaptability of approach adopted by therapists assigned to post-primary settings. One school noted that although their intention early in the project was to apply the Elkan programme to support language learning across all of first year, this was not possible due to the demands imposed by teachers' scheduling. Instead, the school sought to deliver workshops ahead of the beginning of the 2019/2020 school year with a view to embarking upon a supported language programme for all of first year.

Figure 6.10: Therapy Intervention Evidence in PPS_B



One of the sample locations provided a clear example of how a tiered approach could fit with the 'culture' of schools where, for a range of reasons, there may be a reluctance to seek out such services. Highlighting the broader impact of poor socioeconomic factors on children's school inclusion, one principal noted that; *"sometimes the needs of children coming to this school are so overwhelming that we just celebrate the fact that they've made it into school at all"* (PP_A_P).

Another principal highlighted how the location of the school impacted upon perceptions of therapy and attendance at clinic-based, therapy appointments. *"What you have to remember is that in this area, for children from this area, parents place next to no value on therapy and attendance at therapy: they only see it as a cost to them, taxis, buses whatever, its money that they don't have"* (PP2_P1). She went on to explain that student behaviour and reaction to initiatives in school are reflective of their real-world experiences *"these kids don't want to be seen to be going to Speech or Occupational Therapy in school, no way. The first thing they get asked by their peers is 'what's wrong with you then' and of course at home the reaction is 'I hope this isn't going to be costing me anything"* (PP2_P1). In this instance, the assigned therapists were credited by the school leadership in recognising and appreciating this and devising and

implementing a Tier 2 programme for a selected number of students that was described as *"the closest thing to therapy without looking like therapy"* by the school principal. The success of the series of Tier 2 interventions at the school was credited by the project lead to the fact that *"the therapists we had, well they just got the school and the got the kids"* (PPB_T2).

Parents interviewed commented that they were happy that there was a series of supports by way of Speech and Language Therapy and Occupational Therapy available in the school. One parent commented: *"I think it is a good thing, if they need help, then I think my child should get it when they need it"* and appeared to welcome the fact that the service was available in schools. *"I think it will be a big help for my child but it is also for the teacher, right?"* (PPB_Par2). Other parents expressed satisfaction with the availability of services in their own schools as opposed to travelling to a clinic-based service for example; *"it's the first time that I see them doing something that suits us parents, they don't understand the hassle for us going to appointments that we don't know anything about, I mean, It's all about the school at the end of the day, if they want it then I don't see as to why we should run around for it"* (PPB_Par1).

Some of the unique challenges faced in post-primary settings suggest that the dedicated efforts by the Demonstration Project to build capacity, increase understanding and change expectations in such settings required a long-term commitment. School staff interviewed demonstrated a realistic understanding of the challenge in creating change and the long time-frame involved; *"its different here, you can't just changes things overnight, although you might like to, with this work we all know where we want to go, what we don't know often is how long it will take"* (PP_B_T1).

In describing some of the additional needs students in her school present with, one principal commented that *"you know the system here is not about inclusion, it's about competition, most people don't talk about it or give it lip service, but the only thing anyone from the outside cares about is results, that is a sad reality"* (PSB_P1). In a similar vein, one of the therapists assigned to a post-primary school observed that; *"I imagine that in some schools we'll be seen as a distraction from things like mocks, exams, results and so on, I think we'll struggle to make any difference if I'm being honest"*[71]

Another deputy principal interviewed commented that the value for the school community as a participant in the Demonstration Project was that it presented a unique opportunity to *"challenge the generally accepted wisdom"*, *"to put inclusion on the agenda"* and to strengthen school leadership's ability to *"drive forward change, especially for those children who are just as easily overlooked because they don't conform to some people's expectations"* (PSB_T2).

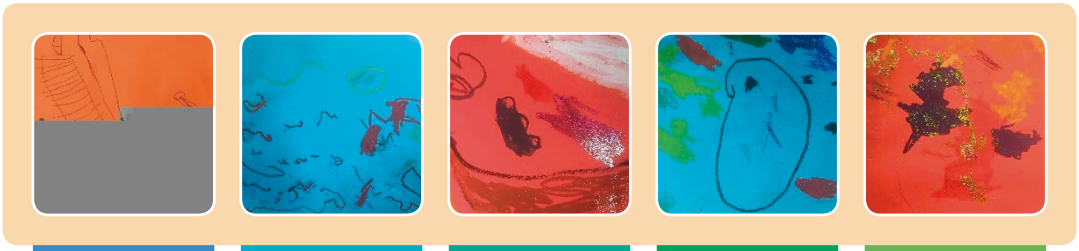
Evidence gathered and analysed highlights the unique nature of examining the application of tiered-model supports and interventions for children in post-primary schools. In the absence of international literature, there is a need to examine the nature of child outcomes and parental involvement in efforts to identify factors that can contribute to ensuring a fully supported, inclusive learning experience for children in second level schools.

71 Therapists Introductory Focus Group: January 2019.

6.2.4 Impact and Outcomes as Experienced in Special Schools

From data synthesis across the varied data sources from special school settings, figure 6.8 identifies components of what the stakeholders found to be best practice in their experiences of the Demonstration Project to date.

Figure 6.11: Key Components for Effective Therapy Provision in a Special School Context



Ensuring therapists, educators, parents and children understand the tiered model and the associated interventions at each tier.

Embedding the Demonstration Project interventions in children's curriculum objectives and developing clear measures to record children's outcomes.

A clear rationale for the allocation of therapists' and educators' time should be articulated.

An appreciation of the complexity involved in developing effective an sustained shared professional learning should be articulated.

Engaging with parents and builidng parental capacity for involvement in the Demonstration Project.

Developing a shared understanding of how inclusion is conceptualised in a special school setting.

In reporting the findings in this chapter, data sources are coded with reference to the codes identified in Table 6.7.

Table 6.7: Special Schools Case Study Data

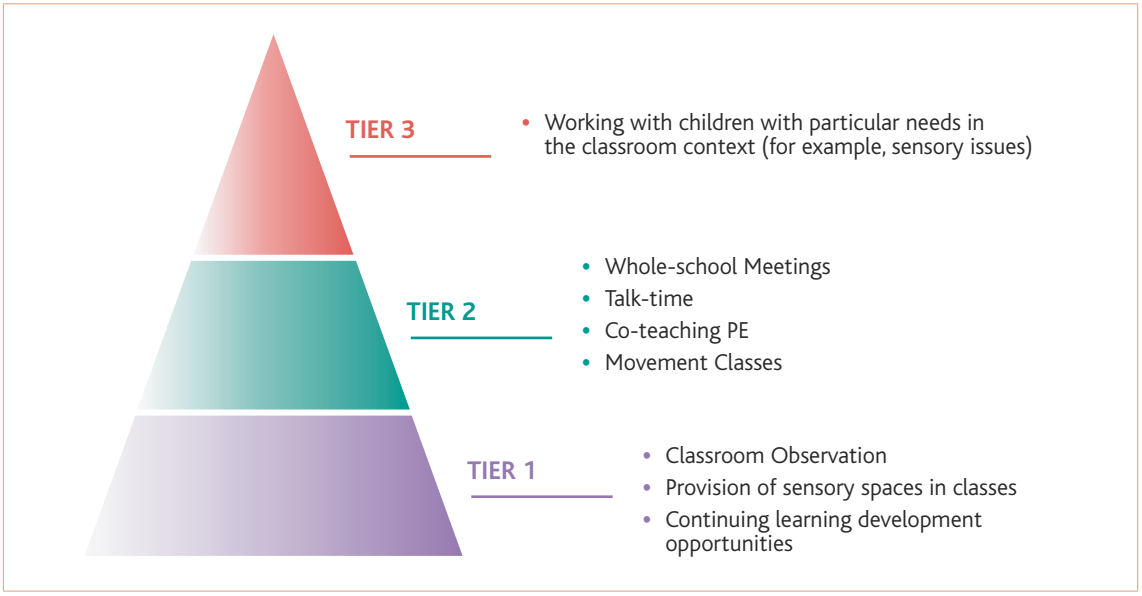
Site	Principal	Teacher	Parent	Child	SLT	OT
SS A	SS_A_PL	SS_A_T1/2	SS_A_P1/2	SS_A_C1/2	SS_A_SLT	SS_B_OT
SS B	SS_B_PL	SS_A_T1/2	SS_A_P1/2	SS_B_C1/2	SS_A_SLT	SS_B_OT

Establishing the implementation of a tiered model of service delivery in special schools that came to the project with some existing complement of both Occupational Therapy and Speech and Language Therapy required additional effort to identify mechanisms that would add value for children, families and schools. While all principals and teachers had an understanding that

the *"Occupational Therapist and Speech and Language Therapist would be given to schools to build capacity and improve outcomes for children"* (SS_A_PL), there was work required to clarify how the tiered model of support was initially understood.

Project therapists assigned to special schools highlighted the need to adapt their approach from very early in the project and to focus on establishing clear understanding of what existing practices could be enhanced. As such, there was a focus on delivering CPD that established a shared understanding of tiered service delivery: *"the best way to start to appreciate what they [special schools] needed was to start with what we could offer"* (SS_A_PL). This approach ensured that the risk of duplication of services was minimised: *"we knew from very early that this was not getting additional therapists, we understood that it was about offering something very new, but we had to work out where that could be accommodated"* (SS_A_PL).

Figure 6.12: Exemplar Interventions Implemented at Each Tier in Special School Settings



In special schools, the CPD programme provided valuable opportunities for all involved to explore the needs of the setting and helped establish how delivering a tiered model of therapy could be tailored to address the needs of the setting. Figure 6.12 above provides examples of the breadth of tiered interventions encountered in this evaluation.

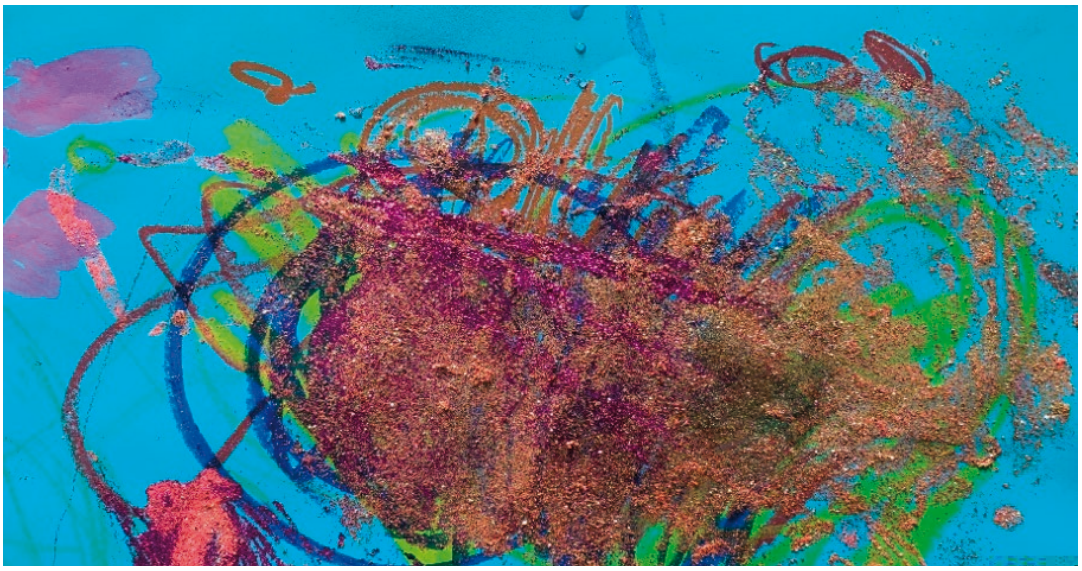
The principal of one special school further noted that as the project progressed, she envisioned that there would be less need for CPD programmes as schools continue to develop more in-depth understanding and put the necessary work practices in place. There was overall agreement from participants interviewed about the potential for shared professional learning from the project, as encapsulated by the principal in SSA: *"I can't stress enough the benefits for everyone with this – this type of input is the way to go – not the traditional view of therapy. Better outcomes for children and families and capacity building for professionals"*.

Data gathered with project therapists stressed the importance of parental/caregiver engagement in ensuring successful implementation of the Demonstration Project objectives in special schools. They observed the importance of establishing collaborative relationships between staff at the participating school with parents and project therapists (World Café OT/SLT). One principal spoke of the need to *"get parents on board early, get them involved in the day-to-day of the project and make it clear what we're all trying to achieve"*. She continued to explain that *"it's not every parent that can or will get involved, that's not just for this project, it is more complicated than that, but the school is a community and the input of parents in whatever way makes all the difference, that's our experience anyway"*. Therapists referred to their former clinical roles where they had been more used to relying on parents to communicate information to teachers, and referred to experiencing challenges in managing information during the project. The experience of working in the Demonstration Project highlighted the need to establish such relationships from the outset, such that clear communication could be maintained throughout the course of ongoing service delivery. Therapists also referred to the time required to meet with and/or communicate with parents, stressing the need to dedicate adequate time to develop these relationships (World Café OT/SLT).

All participants in special schools acknowledged the potential of the Demonstration Project to contribute to their confidence in supporting children and acquire new knowledge, strategies and ideas. The principal in SSB referred to the "severe language and communication needs" and "sensory needs" in the school and the potential impact of the Speech and Language Therapy and Occupational Therapy in relation to supporting teachers to support children in these areas. The potential contribution of the Speech and Language Therapy and Occupational Therapy in this regard was also articulated by the principal in SSB. Due to the timing of the Demonstration Project, it was reported in both special school settings that therapists missed the opportunity to input formally to curriculum objectives in the context of children's individualised planning. Staff and principals in both special schools agreed that this might be a feature of practice in any future role out of the project. All staff agreed that collaboration between staff and assigned therapists was instrumental in ensuring that the Demonstration Project aligned with the curriculum accessed by children in special school contexts. During the drawing activity in SSA with children, the SS_A_T1 remarked on the benefits of Tier 1 and 2 Occupational Therapy input in relation to children's sensory needs as the children engaged in adapted classroom experiences.

Equally, therapists reported that their professional confidence in working in school settings and in the context of curricula had increased and had been enriched through their engagement with educational staff and teachers (World Café SLT/OT). In responding to the post-project survey, therapists (n=27), reported that the needs assessment had informed both the targets set for individual settings and how they had engaged with schools. They also reported that the assessments guided discussions with staff, decision-making in respect of interventions and the setting of targets. Contextual factors including the capacity and willingness of settings were also cited as factors impacting on the Demonstration Project.

Figure 6.13: "My School" as Communicated by SSA_C1



Case study visits highlighted the unique nature of establishing a tiered service delivery model in special schools. Understanding the unique contribution that can be provided by the Demonstration Project was key to ensuring that the implementation of tiered interventions did not result in duplication of existing services or added to the curriculum load in classrooms. Furthermore, the need to dedicate time to building mutual understanding between therapists, teachers, school staff and parents was highlighted as a crucial factor in ensuring successful service delivery.

6.3 Conclusion

Overall, the Demonstration Project provides a valuable mechanism to support educators in providing high-quality educational experiences for children of all ages in the four sectors: ELC, primary, post-primary and special.

ELC Settings:

Overall, the Demonstration Project built on the capacity of ELC practitioners to engage in the high-quality practices which are associated with well-being and development. The project provided parents with easy access to Occupational and Speech and Language Therapy services. The impact of the Demonstration Project in the early years was clearly appreciated with parents and ELC participants recognising the potential of intervention, at this point, to reduce negative child outcomes downstream. The Demonstration Project demonstrated an acute understanding of the diversity of qualifications, expertise and experience in the sector and considered these in developing collaborative working relationships in the settings. Providing supported contexts for all parents that optimise their participation in the Demonstration Project would further enhance parental engagement. The role of the wide range of stakeholders involved in supporting inclusion in ELC settings should be considered and harnessed in the context of the project.

Primary Schools:

Data suggest that key foci of developing best practice regarding the Demonstration Project in the future include ensuring that all participants, including children, have a shared understanding of the tiered model and the associated interventions relevant to each tier. Greater alignment between interventions and curriculum experiences would further enrich children's early learning experiences, supported by a focus on differentiation to meet the needs of individual children. All stakeholders should be clear on the activities located in each tier of the model. Clear structures are required to facilitate therapists' input to curriculum objectives. The complexity of shared professional learning must be understood by both therapists and educators and greater involvement of parents in the project is required. A focus must be maintained on articulating what are envisaged as children's outcomes from the project and how these will be identified

Post-Primary Schools:

Efforts to implement an in-school therapy service using a tiered-model approach in post-primary schools poses a range of unique challenges. It is the sector within which there is little in the way of examples of previous work or international exemplars of practice. There are issues that are posed by the size of the schools, the numbers of students to be served and the numbers of teachers that may benefit from capacity building efforts. Furthermore, there is an issue in terms of how much that can be achieved by a small team of therapists (n=2) in any of the given locations and an issue in terms of how schools translate training and other CPD activities across the whole of the school team. There are also issues that emerge based on the nature of how education is delivered in post-primary schools. For many schools there is an emphasis on exam success and many of the resources are focused solely on those ambitions. The Demonstration Project demonstrated their capacity to respond to these challenges by finding time and space to focus on how the learning experience can be made more inclusive. They also demonstrated the foresight to establish a platform for further, long-term success through initiatives focused on capacity building within the school leadership team and amongst individual teachers. Finally, it should be noted that the Demonstration Project is in a unique position to determine a framework for the delivery of therapy services at post-primary level and provide an exemplar for practice in other jurisdictions.

Special Schools:

Overall, the Demonstration Project provides a valuable mechanism to support teachers in providing high-quality educational experiences for children in special schools. In future development of the project in special school contexts, a clearer understanding of the operation of the tiered model in a special school context is required as a specific area of need compared to the other three sectors. A rationale based on the needs identified in the special school context should underpin the identification of the resources required in terms of both therapists' and school personnel's time required for effective participation in the project. The complexity of developing effective and sustained shared professional learning should be acknowledged and both therapists and school personnel supported through targeted CPD in optimising the opportunities for shared professional learning stemming from the Demonstration Project. Finally, all involved in the project, including parents and children, should be included in a dialogue to support the development of a shared understanding in terms of how inclusion is conceptualised in a special school setting.

7. Discussion

This report began with a descriptive background contextualising the *In-School and Early Years Therapy Support Demonstration Project*, outlining its aims, objectives and purpose. It further positioned the Demonstration Project with reference to literature reporting other international initiatives focused on developing and delivering a tiered model of Occupational Therapy and Speech and Language Therapy services directly to schools. Then, following in-depth evaluation of the project across 2018-2019, the report documented and described the development, organisation and implementation of the project. Having presented the findings relating to impact and outcomes for stakeholders and relevant personnel, this section now discusses the overall successes and challenges of the project with the aim of identifying key issues arising and to consider: what worked well, what could be done differently, and how best the model could be rolled out nationally.

7.1 Contextualising the Demonstration Project

As identified in the literature review, the NCSE Demonstration Project is a unique, new, innovative service model for school-based therapy services in Ireland. It also appears to be innovative regarding international service delivery models for therapy services. Internationally, there are examples of evidence-based tiered models of service delivery for school-based Occupational Therapy and Speech and Language Therapy, particularly in the USA, Canada and the UK. Consistent with the NCSE Demonstration Project model, these tiered models provide a continuum of support within schools, yet there is little evidence of how a tiered therapy model should be implemented. Furthermore, the international evidence is based on models that differ according to the context in which they are developed and operate: there are a wide range of different funding, employment practices, referral systems and care pathways that need to be factored in when considering the evidence (Anaby et al, 2018). Therefore, the evidence of effectiveness needs to be carefully considered and critically interpreted.

The Demonstration Project was charged with developing and operationalising a model of tiered therapy service provision in an Irish context replete with a unique set of conditions that require continuous attention throughout the lifetime of the project. Although caution should be exercised in drawing direct comparisons between Irish and international experiences, common across these studies is ample evidence that the design and delivery of school-based therapy services is complex and requires significant commitment of time and resources at macro levels (for example organisational and management levels) as well as at micro levels (for example collaboration and provision of support for school staff). Notable successes at macro to micro levels that were evident in this evaluation are discussed in the forthcoming sections.

7.2 Project Successes

7.2.1 Demonstration Project Vision as an Evidence-Based Model of Therapy Provision

The Demonstration Project was established with a vision, skills, resources and an action plan that contributes to ensuring any project is successful in its implementation. From the evaluation of project aims and objectives and from the comparison to similar tiered models in Ireland and internationally, it is clear that the Demonstration Project has a shared vision with the tiered model concept that is informed by international best practice. Furthermore, its aims are evidence-informed, in that they describe and communicate a different way of practice that is strengths-based, collaborative, contextual, holistic and focused on maximising capacity building for all. In addition, the Demonstration Project tiered model is described as a model that moves away from the health perspective that is typically oriented around diagnostic assessment and direct intervention between child and therapist. Therefore, it is possible to say that the Demonstration Project vision is clearly aligned with international literature on best practice for delivering a new way of school-based therapy service provision.

7.2.2 Demonstration Project Initiation and Implementation

This new model of therapy provision was delivered on a large scale, with approximately 31 therapists[72] covering a workload[73] of approximately 150 sites, with more than 27,678 children and their caregivers and educators including teachers, SNAs, managers and principals. It is worth noting that the vast majority (91%) of these 150 settings did not have on-site access to such therapy services outside of the Demonstration Project. The findings reveal that, across all settings, almost three-quarters of educators reported that, associated with their participation in this Demonstration Project they had confidence in their ability to identify when a child has special needs, and that they had confidence in their own capacity to be aware of the impact(s) of special needs on a child's functioning and maximising inclusion. When these educators were surveyed about the Demonstration Project and asked if they would recommend it, 93% said yes.

Findings highlighted that the successful implementation of a tiered model of service delivery requires a management structure to deal with the complexities of inter-sectoral work and to guide efforts across a number of phases including (i) a school engagement phase, (ii) a needs-assessment phase prior to (iii) implementation of a tiered model and (iv) ongoing monitoring processes that support model fidelity and quality. All elements were identifiable in the Demonstration Project, although in different levels of development across the 150 sites and across the school year, which is to be expected in a project of such breadth.

72 The therapy staffing varied across the year as some staff left, leading to the need for further recruitment.

73 See workload versus caseload, Workload model statement jointly developed by the American Occupational Therapy Association and the Speech, Language, Hearing Association, accessed https://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf.

7.2.3 An Emerging Model of Inter-Sectoral Engagement, Collaboration and Service Delivery

The Demonstration Project sought to establish the delivery of a model of service provision of in-school therapy by efficiently leveraging the experience and expertise from traditional healthcare providers. The findings point to a project that established a governance and management model that supported the rapid recruitment and induction of a team of highly experienced Speech and Language and Occupational Therapists. Furthermore, the findings indicate a project leadership that made pragmatic decisions to ensure that (i) supervisory and management functions were in place from the outset, (ii) there was a mechanism for engaging participant locations and a complement of resources to support this and (iii) a tiered model of service delivery could be implemented while ensuring that all stakeholders developed a full and thorough understanding of the composition and nature of the service.

7.2.4 Evolving New Operating Practices: Management

Establishing governance systems and service processes for inter-sectoral work is complex and time-consuming. The short preparatory time period available to the management team was such that many of the systems and processes that supported key functions relied on the adoption of existing management practices across partner organisations in particular, the NCSE and the HSE. The inter-agency management model established for the Demonstration Project provided a management support infrastructure for incoming staff from the outset of the project. The Demonstration Project has been structured such that individual therapists have a discipline-specific manager (seconded from HSE). Furthermore, a discipline-specific clinical lead is available to provide supervision and expert guidance to Speech and Language Therapists and Occupational Therapists.

7.2.5 Evolving New Operating Practices: Recruitment and Data Recording

Process evaluation identified that the Demonstration Project was successful in establishing a recruitment model that supported initial and ongoing recruitment to fill the posts assigned to the project. While therapists were recruited with support from the HSE, they were working within the NCSE Project Management team. This inter-sectoral model required considerable time and resource commitment to ensure HSE services were not impacted, in addition to ensuring success of the Demonstration Project implementation. However, in this way, this new Irish initiative began by bringing therapists formally into the education system, to deliver an educational model of therapy practice under the direction of the NCSE. This resulted in enabling therapists to shift away from ways of practice that are more typical of a health setting where medical models predominate.

The unique nature of this project is such that the management team did not have an exemplar data management model or infrastructure for electronic data. As such, the Project Management Team were required to develop their own systems and processes as they began to initiate project activities. One key decision was the introduction of the centralised 'Target Tracker' document where the targets (goals) being set for the participating schools and ELC settings could be

mapped.[74] The Target Tracker allowed both Clinical Leads periodic visibility on the nature and frequency of tiered interventions agreed between project therapists and the corresponding team in each setting. Clearly, significant efforts were placed on designing and implementing procedures for project management, and to ensure project success.

7.2.6 Development of a Staff Induction Programme

This evaluation report highlighted the development of inter-professional working practices that match emergent best practice examples from other school-based therapy provision programmes. A culture of inter-professional sharing and support was facilitated and promoted with bespoke learning resources developed and shared in a work environment where relationships clearly transcended more traditional professional boundaries. On examination, the induction programme content shared with the evaluation team highlighted international and Irish examples of good practice school-based therapy provision alongside resources that served to provide a platform for understanding the educational contexts for early years, primary, post-primary and special education sectors.

7.2.7 School Engagement and Needs Assessment

According to the NCSE, successful implementation of a tiered model requires as a key element *'embedding of a continuum-of-support framework into schools' policies and practices'* (p. 9). To do this successfully, the first phase of the implementation plan is to conduct what they call a 'consultation phase', which requires *'sufficient time to engage with parents, schools and other stakeholders to clearly explain the proposed model and ensure it is understood, listened to and responds to people's concerns and questions about the model; refine and/or make necessary changes to the model before implementation'* (NCSE, 2017, p. 9). Hence, a school engagement model was developed, and a phase of school engagement implemented to 150 educational settings over the course of the regulation school year. Participating schools and ELC settings were aggregated across four geographical areas with responsibility for approximately 80% of locations (n=119) managed via the Dublin hub and the remaining 20% (31) locations managed by the staff assigned to the Kildare hub.[75] The Project Management and Therapy Team developed information sessions and CPD workshops which were delivered to all educational settings and their associated staff and families in order to explain the project. These efforts included the development of training materials and information resources to ensure the project was communicated in multiple ways and to aim for maximum shared understanding.

A needs assessment was included in the implementation and engagement phase, which involved a collaborative process of screening and profiling of needs to be conducted within each educational setting via the project team. This approach was central in the Project Action Plan and aligns with best practice to ensure each child has the right support at the right time.

74 The Target Tracker was built as a linear, multi-data entry system using Microsoft Excel, a readily available and easy to use spreadsheet platform which provides the opportunity to display text and numerical data sets using graphing sets and allows for some manipulation of data and inter-data calculations.

75 Nesta, Kylemore Road, Dublin 15 and The Education Centre, Kildare Village.

This is a key strength of the Demonstration Project as it is also aligned with existing policy landscape in Ireland that is supporting a continuum-of-support framework (Department of Education and Science, 2007; Department of Education and Skills, 2017a). Having a regular process of screening contributes to the success of the model.

7.2.8 Implementing the Tiered Model of Therapy Provision

The Demonstration Project, in efforts to address the need to establish a harmonised understanding of tiered service delivery, decided to make it scalable and to focus just on delivering Tier 1 in the first phase of the action plan.[76] Hence, Tier 1 was the most developed aspect of the project, which meets the long-term goal of establishing a strong Tier 1 as part of a tiered model of service delivery. By July of 2019, 1,235 Tier 1 targets were set and delivered to the majority of the 150 settings, which amounted to 72% of targets overall, with the majority being achieved by the end of the year.

The tiered model was implemented in phases with Tier 1 being the sole focus of the autumn of 2018 while Tiers 2 and 3 were gradually introduced in spring 2019. By the end of the year, the tiered model was applied in the majority of settings, with Tier 3 programmes emerging in $^1/_3$ of the settings. By July 2019, a combined **1,736 targets were set across the four setting types** (i.e. ELC settings, primary schools, post-primary schools and special schools) with a completion rate of over 67% recorded. Many of these represented Tier 1 interventions focused on capacity building and whole-school interventions, which are key characteristics of the tiered model of provision. While the phased approach resulted in a short timeframe overall for evaluating the model as a holistic approach, there is emerging evidence of the interaction between tiers and a broadening of ways of practice so that therapists can be more effective in working in a school context, and so that educators have ongoing therapy support that is more attuned to their needs and the needs of the child, and therefore provides a service that is beginning to provide the right support at the right time.

7.2.9 Fidelity to Tiered Service Delivery

As noted in the literature review and in the evaluation of the implementation process, the Demonstration Project was tasked with establishing and implementing a tiered model of therapy that was to be adapted for school-based therapy practice. Evaluation of fidelity to the tiered model required triangulation across data sources. From analysis of interview and survey data, evidence shows that efforts by the Demonstration Project Management Team and individual therapists ensured that staff at participant schools and ELCs increased their awareness and understanding of the nature of tiered service delivery during the early phases of their engagement. From ongoing Target Tracker analysis, it was clear that many aspects of a tiered model were being implemented that included new ways of working for therapists, such as on-site coaching or modelling of strategies for capacity building.

76 As noted in section 3, the RtI approach similarly operates a gradual implementation process that is designed to be tailored to the capacity of each school setting to engage in a tiered model of provision.

7.2.10 Outcomes for Knowledge Translation and Capacity Building

A variety of factors determine optimal service delivery outcomes including (i) relationship development between educators and therapists, (ii) effective knowledge translation and reciprocal capacity building (White and Spenser, 2018; Missiuna et al, 2012). It is clear from the evidence in sections five and six, that the project team understood this, and emphasised efforts dedicated to relationship building between professions as well as service users. With regard to relationship building, it has been documented across multiple studies, that a school-based therapy tiered approach needs regular dedicated time available for effective collaboration (White and Spenser, 2018). This is essential in order to build consistent relationships with the same professionals over time, and to build trust and help break down professional boundaries (McKean et al, 2017). With regard to knowledge translation and capacity building, this refers to a reciprocal, two-way process of transferring knowledge, which relies on the relationship work that has begun to develop. Central to knowledge translation is a focus on the appropriate and judicious use of techniques such as coaching as an approach to work together to implement a new strategy, with or for the child, to determine through trial and error whether it might work and to problem-solve together to enhance student participation and inclusion (McKean et al, 2017). Therefore, participation and inclusion are an outcome of strong collaborative working, with a joint focus on shared knowledge in the context of learning needs. Classroom staff in each setting commented on this aspect as one of particular value in the Demonstration Project compared to traditional clinic-based therapy provision. In the Demonstration Project, knowledge translation was primarily evident through the process of delivering whole-school CPD, and provision of resources which were identified as the main areas of input across all four sectors of the project, in early years, primary, post-primary and special school settings. However, repeatedly across the data, participants referred to the potential of the project to contribute to children's inclusion, learning and development. Therapists noted that children were better supported to enable participation and inclusion in their respective settings (World Café OT/SLT). In the post-survey, participants referred to the Demonstration Project as building capacity and inclusion in schools/ELC settings participating in the project, with 98% of therapists indicating that this had been achieved to a great/fairly great/moderate extent.

7.3 Challenges

This section presents notable challenges that were evident in this evaluation, which are discussed in context of the successes, alongside the implications for ongoing development and replication of the Demonstration Project into the future.

7.3.1 Inter-Sectoral Service Provision: Management, Recruitment and Processes

Mirroring international tiered service provision models, the Demonstration Project comprised multiple inter-sectoral stakeholders bringing many challenges and additional barriers to the efficient delivery of school-based practice. For example, in a systematic review of health and education collaboration (Hiller, Civetta and Pridham, 2010), evidence shows that typical barriers can include issues related to service structures (where different team members are employed by different employees resulting in lack of clarity around decision-making, pay

scales or employment status), different case or workloads, different resources and different work patterns across educators and therapists. These issues pose a risk to ensuring efficient, collaborative work practices on the ground between therapists and educators. Not surprisingly, perhaps, the Demonstration Project experienced similar challenges to those noted in the international literature in its efforts to operate and achieve within an organisational framework that endeavoured to represent the broad spectrum of stakeholders from the various sectors. This, by its nature, ensures representation and collaboration, but also deliberation and discussion, which in turn impacted on its capacity to implement a tiered model effectively within the space of a single year.

This was most apparent in relation to the recruitment and documentation processes that required significant inter-sectoral working. Across the lifetime of the project, the inter-sectoral structures caused some levels of confusion with regard to management, supervisory and professional/clinical support arrangements for individual therapists. Although the recruitment arrangements put in place for the project facilitated the rapid employment and management of experienced therapy staff, it did not provide flexibility required to support quickly backfilling vacant posts and/or identifying therapists that have a specific range of skills or experience matched with the tiered model of therapy service delivery proposed in the Demonstration Project. The evaluation of the recruitment and employment framework confirms that utilising human resource capacity from within the HSE as a partner in this project was a pragmatic decision that supported the rapid employment of therapy staff for the Demonstration Project. Future reliance on such a model however will likely lead to delays with recruitment, a lack of flexibility in defining job specifications and requirements, and issues with the rapid backfilling of posts. Reliance on the recruitment model and practices of a partner organisation such as the HSE will significantly limit any future ambitions to scale the project beyond its current operational scope. As the project progresses, a more flexible recruitment model supported by a management structure that is streamlined to support the day-to-day management functions required by a large team of inter-disciplinary therapists is envisaged, while ensuring also that the existing vision of therapy supports concerned with promoting inclusion and participation in education is maintained.

Documentation processes were another challenge. The evolving nature of the project saw issues emerge during its implementation relating to, for example, access, consent, GDPR and storage. One key decision during the 'start-up' phase of this project was the introduction of hard-copy files for individual settings. The hard-copy files were stored by the project team and were not shared with individual settings (i.e. ELC settings and schools). While the hard-copy files were relatively small in January 2019, by July 2019 the files had significantly increased in size – this placed increased emphasis on the need to consider storage solutions as the project progresses into its next phase of implementation. In such circumstances, the management team did not have an opportunity to reflect on and examine the nature of the data captured, what storage requirements were necessary and crucially the manner and nature of how this data would be accessed. This presented a range of complex data governance and access issues for the broad range of stakeholders involved in the project requiring deliberation as to what access can or should be granted to elements of the recorded data within the existing data governance structures that are in place for both DES and the HSE.

The cross-sectoral nature of the project also posed challenges for how data was recorded, managed and accessed throughout the project resulting in the management team dedicating ongoing resources to resolve throughout the project.

Certainly, the Demonstration Project should be commended for their efforts to develop, implement and maintain not only a file-based recording system but also a centralised 'Target Tracker' system that would serve to record and map tiered implementations being set for the participating schools and ELC settings.[77] It was evident that significant effort was dedicated to the recording of data pertaining to project locations and to individual children by therapists and staff at participating schools and ELCs. However, it remained unclear at the end of the evaluation whether or not reciprocal arrangements had been considered that would govern access to project documentation held both centrally and at project locations relating to implementation, progress and overall governance. The current Target Tracker in its current form is not sustainable as a secure data management or reporting tool. Consideration should be given to alternative, third-party platforms such as that offered by companies such as Salesforce, Microsoft or others. Existing data recording and note-taking processes are such that there are no systems in place to guard against duplication, ensure quality standards for data management and data sharing or minimise inefficiencies in recording key data. A comprehensive data sharing policy with the appropriate protocols requires urgent attention to ensure the ongoing security of and appropriate access to service level data. In addition, the development of a platform that provides data security, access, recording and interrogating features with minimal effort on the part of the management team is a consideration for future enhancement of the Demonstration Project.

7.3.2 Induction and Education Programme for School-Based Practice for Therapists

The induction programme was a successful development for implementing the Demonstration Project in its first year. However, it merits attention to examine how it can be employed systematically into the future as on-boarding, upskilling practice for all staff and, consequently, to support the ongoing fidelity of implementation of the tiered model. Although successful in delivering comprehensive and peer-led induction opportunities that ensured rapid knowledge and skills development for therapy staff at the outset of the project, this induction programme was not sustainable and did not provide an equitable platform for knowledge and skill development for staff recruited later over the project lifetime. Furthermore, project therapists identified the need for advanced CPD for developing new knowledge in capacity building, knowledge translation and collaborative consultation which are core skills required for this new way of therapy provision. In transitioning between clinic-based services and a service embedded in education settings, there is a requirement for a natural evolution of skills and experience for therapists. It does, however, point to the need for additional support in terms of training, skill development or quality assurance mechanisms to ensure that the focus of the tiered model remains on ensuring inclusive and equitable participation in educational curricula.

77 The Target Tracker was built as a linear, multi-data entry system using Microsoft Excel, a readily available and easy to use spreadsheet platform, which provides the opportunity to display text and numerical data sets using graphing sets and allows for some manipulation of data and inter-data calculations.

Furthermore, other such programmes have developed their models of school-based interventions by integrating available evidence with professional experience and family perspectives so that the context in which it is to be delivered can be considered (e.g. Roulstone et al., 2015; Pollock et al., 2017). Considering that many of the skills that are specific to delivering services in education are currently considered to be at postgraduate level and are not part of the undergraduate professional training programme for Speech and Language Therapy or Occupational Therapy, increased training on coaching, and collaborative consultation in the context of delivering the tiered model of supports ought to be considered. Finally, access to a dedicated educational advisor on the induction team would build on the staff capacity to tailor strategies and develop curriculum and education-oriented programmes more efficiently.

7.3.3 Project Initiation Phase: Engagement and Needs Assessment

Overall, the scope of the project as it was established was ambitious, and commencing the project close to the start of the regulation school year resulted in less time for the project to prepare and establish clear processes and supports that would platform the work programme. As mentioned throughout this report, the limited time in which project therapists had to establish the relationships that would serve as the infrastructure to support the delivery of services into schools and ELCs led to a number of challenges that were addressed to varying degrees on a setting-by-setting basis. Time required to build relationships with schools and ELCs within the timeframe available to the project may have been underestimated and resulted in less time available to project teams in participating settings to comprehensively address their specific needs. Finally, international evidence from school-based tiered models (for example RtI) shows that the role of the on-site project teams is an essential feature of the programme, where the team is responsible for the implementation and monitoring of the tiered model on-site.[78] Without development of the role of the local project team, the implementation process may be at risk of inconsistent implementation and poor treatment integrity. The composition of a project team needs to be clarified and reviewed. This might involve a specialist teacher role, a parental representative and relevant stakeholders such as educational psychologists as well as the principal and therapist. This extended team may not be required at all settings and may not be involved in the ongoing delivery of services to schools and children, but can provide a strong role in developing and guiding the strategic delivery of services. A team with such diversification of representation could provide a quality assurance function to the service delivery process and should plan to have regular meetings and ensure good communication with all involved, possibly through a project lead appointed in each site. The role of parents should also be clarified, and greater emphasis placed on this for ELCs, primary and special schools.

The relatively short time-frame available to the Demonstration Project to prepare, develop and implement the new service delivery model to schools posed further challenges to the optimal establishment of such services. Preparation for the commencement of the project focused appropriately on addressing issues such as recruitment, inter-agency working and establishing day-to-day operational capacity, leaving little time to examine the nature and scope of the needs in participant settings. This approach was central in the Project Action Plan and aligns with best

78 https://rti4success.org/settings/default/files/NCRTI_District_Rubric%20and%20Worksheet_061112.pdf.

practice to ensure each child has the right support at the right time as noted (Department of Education and Science, 2007; Department of Education and Skills, 2017a, 2017b, 2019a, 2019b; Inter-Departmental Group, 2015; NCSE, 2014, 2017). Having a regular process of screening contributes to the success of the model. Ideally, a corpus of information detailing the inclusion needs of individual settings would be available to the Demonstration Project team and would inform forward planning and the prioritisation of work activities and processes. However, it appears that no such assessment of capacity process was available at the outset of the project. As the project was scheduled to commence during a period coinciding with the restarting of schools at the end of the summer break, participating settings were not engaged in an assessment process to establish their readiness to take part in the project or to establish a baseline of needs to be addressed and prioritised. Instead, each site was invited to participate in the project, with follow-on information sessions held to communicate the project goals and principles. Although there was evidence of screening and profiling of need conducted collaboratively within each setting by project teams, the approach taken was by its nature inconsistent and there was limited evidence of a clearly articulated identification of need for participant settings overall. While the actions taken by the Demonstration Project were in keeping with the objectives of the project to address need and build tiered service delivery for each location, this resulted in an opportunity missed that could inform a tailored response to the tiered approaches in other locations or across other such initiatives. Although outside of the scope assigned to the Demonstration Project, it is likely that a regular systematic needs-assessment process will be required to determine needs in future implementation. It is also important to note that a more detailed profiling of need/needs assessment would contribute more effectively to resource management. The production of a report that documents how setting demographics (for example, number of staff and children in settings) are utilised to inform the planning and implementation of the tiered model of support would be a valuable output from this project. Such an output would support (i) future selection of settings, (ii) the future sourcing and deployment of resources and (iii) the development of a model that articulates appropriate staffing ratios per setting.

7.3.4 Implementing the Tiered Model of Therapy Provision

There were a number of challenges in implementing the tiered model, alongside the successes. As noted, by July of 2019 1,235 Tier 1 targets were set and delivered to the majority of the 150 settings, which amounted to 71% of targets overall, with the majority being achieved by the end of the year. While this was a logical response considering the size of the project and the time available to them, it resulted in a delayed ability to implement and deliver a flexible, responsive model that could be evaluated in its entirety. Although it gave therapists and educators time to understand Tier 1, it required practitioners to prioritise differently rather than beginning with addressing any special educational needs and specific inclusion issues of individual children that were a concern in each of the 150 sites from the outset. The outcome, however, was that therapists were prioritising delivery of whole-school CPD most often, thus limiting the time they had available to spend on-site attending to the relationship work and knowledge translation for more specific needs and other aspects outlined earlier.

While the tiered framework established for this Demonstration Project highlights a general understanding and approach to Tier 1, a clearer articulation of what constitutes the 'consultation phase' versus Tier 1 intervention would benefit the overall project in the context of implementing a tiered model of therapy support would be a valuable output from this project. As noted, targets set as Tier 1 included activities such as explaining the Demonstration Project, rather than delivering Tier 1 interventions such as whole-school CPD. Establishing a clearer phase of consultation separately to a Tier 1 intervention would be a valuable output from this project. Moreover, such separation would facilitate the clear establishment of targets for Tier 1 that align with international best practice. From analysis of the project documentation combined with the survey and interview data, it is clear that a clear definition of what constitutes Tier 2 interventions in an Irish context remains unresolved and will take further implementation to adequately explore. Further work to establish what it means to embed therapy into a curriculum context would be helpful and this issue needs to be resolved in the context of providing the right supports at the right time as a means to successfully implement the tiered model. Similarly, data confirms the challenge in implementing Tier 3 as a particular focus of concern and one that was only being explored and resolved during the final months of the project where it was evident that interventions at this tier were successfully implemented.

Overall, the future success of similar projects like this will depend on the development of a clearer articulation of what constitutes each of the tiers as a means of delivering evidence-based practice. The further clarification of Tier 1, 2 and 3 interventions would also be a benefit to determine what education-focused, capacity-building, collaborative interventions look like at each tier. This requires therapists to develop a strong knowledge base of collaborative consultation approaches and curriculum design, to be best able to design tailored interventions at each tier, according to the vision and aims of this model.

7.3.5 Broader Considerations to Support Development and Future Practice

This evaluation of the implementation of a tiered model of therapy services to schools and ELCs in Ireland presents a level of success that will contribute to furthering the ambition of more inclusive education for all children. As noted in the literature review and in the evaluation of the implementation process, the Demonstration Project was tasked with establishing and implementing a tiered model of therapy that was to be adapted for school-based therapy practice. This required recognising lessons that could be learned from international exemplars of good practice but reflected the specificity of the unique and nuanced nature of the education and health sectors in Ireland.

This is an ambitious project which has required the project team to develop a new, innovative service, which employs a new way of working for therapy service delivery (the tiered model) while at the same time implementing and managing a project. This requires significant time and effort to work at a theoretical and best practice level while also addressing the complex organisational and management requirements of delivering a substantial inter-sectoral project. During the evaluation it was noted that the project was slow to rollout, with concurrent training needs emerging across the year for the therapy teams, alongside challenges in being able to

document outcomes and impact. The findings of this evaluation identify the need for a clearer planning phase to ensure that the necessary infrastructure is in place to ensure the smooth delivery of a tiered model of therapy services delivery in a future rollout. Moreover, the future effectiveness of implementing a tiered model of service delivery will require clear phases of service development and delivery. Further efforts are needed to explore models for enabling educational settings to self-assess their capacity and readiness to engage with the tiered therapy model. Once a setting has agreed to participate in the in-school therapy services, then the project team that is established needs to have a clear role in relation to what is expected for screening, monitoring, staff CPD and ongoing assessment of progress and adherence to the tiered model, including fidelity. A needs-assessment protocol needs to be clearly defined and established with clarity on best practice in implementing this phase of the NCSE therapy model. Therefore, implementation of the entire model requires ongoing monitoring to ensure it meets treatment integrity and maximises the full potential of the tiered approach. It was not possible to fully determine this within this first year of the project, as the evidence showed that for many settings, they were still at early stages of engagement. Finally, the key characteristics of a successful model will require ongoing evaluation, as there was little evidence of a fit-for-purpose induction training programme on knowledge translation or educationally related service delivery for Occupational Therapy or for Speech and Language Therapy at the outset.

The Demonstration Project sought to establish the foundation for a new way of working that was a significant shift from more traditional ways of therapy practice. A broader practice challenge that emerged concerns how to ensure that tiered service delivery retains a unique identity that differentiates itself from more traditional therapy service delivery. Tier 3 is closest to clinic-based therapy practice but even where individualised intensive support is given, as highlighted previously, it is still underpinned by the principles of collaborative consultation and co-teaching or coaching children with increasing needs. However, the nature of the direct intervention at a Tier 3 level will differ between traditional clinic-based and school-based practices as therapists in school-based practice are embedded in class/room contexts underpinned by principles of collaborative consultation and co-teaching or coaching. The process of clearly understanding the role differences will become clearer over time, as the project continues to advance and evolve.

Building upon and contributing further to the achievements of this project will, however, require change from stakeholders outside of those involved in the Demonstration Project. From our knowledge of undergraduate and postgraduate education of therapists in Ireland, there is a clear knowledge gap on school-based therapy practices that warrants further development. Currently in Ireland therapists do not receive instruction nor are assessed on knowledge or abilities to work in a collaborative consultation model, nor to work from a whole-school, strengths-based perspective. While the Demonstration Project team established a training and induction programme which served as a strong starting point, this must now serve as a catalyst for further change in the education and training of graduate Speech and Language Therapists and Occupational Therapists in Ireland. Furthermore, therapists in existing practice will require ongoing CPD support to meet the significant learning needs for an innovative project such as this for professions as a whole. Further investment into postgraduate education and development of CPD resources, it is anticipated, will provide a solution to this unmet need and be a significant outcome of the Demonstration Project. It is reasonable to expect that the continued success of the Demonstration Project will serve to establish them as leaders supporting further, ongoing

efforts to ensure that professional bodies rise to their responsibility to ensure that their professions are skilled and experienced such that they can easily work within new, emerging models of practice. This is not an unexpected outcome, as it was also an outcome of the P4C project in Canada, where postgraduate online modules were developed as a consequence of this government-funded project, to ensure therapists received the necessary education and mentoring required to work in school-based practice in an evidence-informed way (Pollock et al., 2017). Postgraduate therapy programmes could be developed similar to those in Canada and the USA to provide this expertise to school-based therapy practitioners and fill the gap in practice knowledge.

Overall, there appears to be a consensus internationally that the efforts required to develop new models of school-based practice are worth it as they reap benefits at multiple levels and maximise resources for all involved towards inclusion (WHO, 2011). Varied studies have shown that this integrated school-based model results in enhanced outcomes for children regarding communication, academic skills, transitions, social and behavioural skills, and is associated with high levels of educator satisfaction from this collaborative approach to service delivery (e.g. Anaby et al, 2018; Oakes et al., 2013; section 3 of this report). However, these outcomes and impacts require therapists who bring advanced knowledge and skills which are only emerging in therapy practice in Ireland. For example, the new model of practice established in the Demonstration Project aims to include a universal perspective (in some cases incorporating a Universal Design for Learning approach), differentiated instruction and accommodations, oriented around collaborative consultation, coaching and dedicated time for knowledge translation and problem-solving. These advanced practice skills will mature as time, experience and further knowledge is accrued. It can be anticipated that this maturation will be reflected in turn in the induction programme designed and delivered by the Demonstration Project team and in the targets proposed for service implementation. Developing the therapist knowledge base for tiered models will contribute to an increase in the collective understanding of what constitutes Tier 1, 2 and 3 interventions and service provision as applied in the context of Irish schools and ELCs. The increasing clarity of understanding will make it easier for future iterations of the Demonstration Project to measure fidelity, establish quality assurance practices and benchmark practice in a uniquely Irish context.

Therapists did not receive training on coaching, differentiated instruction or Universal Design for Learning before the Demonstration Project began. Neither did they appear to have a strong knowledge base on the areas of the curriculum where therapists can support learning, nor the knowledge on how best to establish education-based goals in designing interventions that are informed by evidence. This reflects the overall approach taken in this Demonstration Project to develop the in-school therapy service while at the same time implementing it. The replicability of this project will depend on the capacity of the Demonstration Project team to address many of these issues. However, the broader challenges of resource management, recruitment and coverage will need to be addressed if an effective, evidence-based service model is to be implemented on a bigger scale.

From this evaluation, it is clear that the delivery of services in an efficient manner across health and education sectors is complex and requires bespoke solutions for some of the challenges that emerge. The experiences of therapy and educational staff in the Demonstration Project demonstrate that the extra challenges of working across these two different employing bodies

has limited the project's capacity to deliver the new programme effectively and is identified by the project stakeholders as a barrier. However, according to the WHO (2011), the inclusion of children with disabilities into educational settings is the responsibility of the educational system in each state, as it is they that are best able to determine the special educational needs of each student. In their report they highlight that where children with special needs are served under health or social services for example in relation to education, that this reflects a welfare approach rather than equality of opportunity. In health, a welfare approach is typically deficit-oriented and works to address these deficits at an individual level. In contrast, school-based practice is oriented more on a strengths-based model of support, with less emphasis on diagnosis and more on education need to be addressed through whole-school, contextual responses. Overall, the necessity of having a clear organisational framework for service delivery that maximises the capacity to deliver this inclusive, strengths-based philosophy has been identified as an essential feature (Anaby et al., 2018). According to the evidence and as acknowledged by the WHO, the educational sector is best placed to take responsibility for leading and delivering a cohesive inclusion programme for the education sector that includes school-based therapy services.

7.4 Conclusion

This report aims to provide a comprehensive overview of the establishment, commencement and implementation of the In-School and Early Years Therapy Support Demonstration Project, which was established and conducted in 2018-2019. The report has documented the many successes and challenges of the Demonstration Project to date. Overall, the project is showing signs of impact with capacity building efforts in particular contributing to educators overall reporting satisfaction with the project and reporting also an increased ability to identify early signs of special education need alongside, a sense of confidence emerging in maximising inclusion of children with additional needs.

Inclusion and special education are often presented as divergent concepts. However, the United Nations Scientific and Cultural Organisation (UNESCO) (2005) describes inclusion in terms of *Education for All*, noting that:

> *Education for All means ensuring that all children have access to basic education of good quality. This implies creating an environment in schools and in basic education programmes in which children are both able and enabled to learn. Such an environment must be inclusive of children, effective with children, friendly and welcoming to children, healthy and protective for children and gender sensitive.*
>
> (UNESCO 2005, p. 10).

While acknowledging the complexity of inclusion as a concept, in the context of the analysis of the Demonstration Project data, inclusion is conceptualised with reference to the UNESCO definition above and is equated with providing child-friendly learning environments where children's holistic development is fostered, and children are enabled to achieve their full potential.

Repeatedly across the data, participants referred to the potential of the project to contribute to children's inclusion, learning and development where therapists noted that children were better supported to enable participation and inclusion in their respective settings, with 98% of therapists indicating that this had been achieved to a great/fairly great/moderate extent. Overall, across all four settings, data suggest that key foci of developing best practice in relation to the Demonstration Project in the future include ensuring that all participants, including children, have a shared understanding of the tiered model and the associated interventions relevant to each tier. As the Demonstration Project is embedded in the child's educational experience, interventions should be linked with and embedded in curriculum objectives, with clear measures identified to record and assess children's outcomes.

It is important to note that international evidence for outcomes of inclusive educational settings is inconclusive, and as noted by the WHO (2011), most of the evidence focuses on implementing an inclusive approach rather than on outcomes or impact. While some evidence shows benefits in terms of social, communication and behavioural skills, for children with special education needs in inclusive settings, these benefits appear to be dependent on inclusive practices that are relevant and comprehensive: that provide tailored, well-resourced interventions and individualised support where necessary. Without this, students can be placed in inclusive contexts but still experience exclusion (Timmons and Wagner, 2009). For the Demonstration Project, it appears that it is in new uncharted territory and may well be the first project of its kind to gather evidence on outcomes and impact.

References

AOTA (American Occupational Therapy Association) (2008). FAQ on response to intervention for school-based occupational therapists and occupational therapy assistants. AOTA.

AOTA (American Occupational Therapy Association) (2011). Transforming caseload to workload in school-based Occupational Therapy Services. AOTA, accessed: https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/CY/Fact-Sheets/Workload-fact.pdf.

Anaby, D., Campbell, W., Missiuna, C., Shae, S., Bennett, S., Khan, S., Tremblay, S., Kaluba-Lukusa, J., & Camden, C. (2019). Recommended practices to organize and deliver school-based services for children with disabilities: A scoping review. *Child Health, Care and Development*, 45, 15-27.

Apthorp, H., Randel, B., Cherasaro, T., Clarke, T., McKeown, M & Beck, I. (2012). Effects of a supplemental vocabulary program on word knowledge and passage comprehension. *Journal of Research on Educational Effectiveness, 5*, 160-188.

ASHA (ND). School-based service delivery in Speech-Language Pathology. Retrieved from: https://www.asha.org/SLP/schools/School-Based-Service-Delivery-in-Speech-Language-Pathology/.

Atkinson, P. & Coffey, A. (2011). Analysing documentary realities. In Silverman, D., ed., *Qualitative research: Theory, method and practice*, 3rd ed., London: Sage, pp. 77-92.

Axford, N., Little, M., Duffy, l., Haran, N. and Zappone, K. (2004) How are our Kids? Children and Families in Tallaght West, County Dublin. Tallaght: Childhood Development Initiative. Available at https://www.drugsandalcohol.ie/5903/1/Tallaght_How_are_our_kids.pdf.

Bayona, C., McDougall, J., Tucker, M. Nichols, M. & Mandich, A. (2006). School-based occupational therapy for children with fine motor difficulties: evaluating functional outcomes and fidelity of services. *Physical & Occupational Therapy in Pediatrics, 26*(3), 89-110.

Bazeley, P. (2009). Analysing qualitative data: More than identifying themes. *Malaysian Journal of Qualitative Research*, 2 (2), 6-22.

Bazyk, S., Michaud, P., Goodman, G., Papp, P., Hawkins, E. & Welch, M. (2009). Integrating occupational therapy services in a kindergarten curriculum: A look at outcomes. *American Journal of Occupational Therapy, 63(2)*, 160-171.

Bazyk S. & Arbesman M. (2013) Occupational therapy practice guidelines for mental health promotion, prevention, and intervention for children and youth. Bethesda, MD: American Occupational Therapy Association.

Bissell, J., & Cermak, S. (2015). Frameworks models and trends in school-based occupational therapy in the United States. *Israeli Journal of Occupational Therapy, 24(2-3)*, 49-68.

Blackwell, A. & Dunn, W. (2016). Active ingredients for an embedded intervention within the early childhood classroom. *Journal of Occupational Therapy, Schools, & Early Intervention*, 9(2), 125-141.

Bond, C., Woods, K., Humphrey, N. Symes, W., & Green. L. (2013). The effectiveness of SFBT with children, schools and families: A systematic and critical review of the literature from 1990-2010, *Journal of Child Psychology and Psychiatry*, 54 (7), 707-723, DOI: 10.1111/jcpp.12058.

Bonnard, M. & Anaby, D. (2016). Enabling participation of students through school-based occupational therapy services: Towards a broader scope of practice. *British Journal of Occupational Therapy, 79(3)*, 188-192.

Bose, P., & Hinojosa, J. (2008). Reported experiences from occupational therapists interacting with teachers in inclusive early education classrooms. *American Journal of Occupational Therapy*, 62 (3), 289-297.

Braun, V., Clarke, V. & Terry, G. (2015). Thematic Analysis in P. Rohleder, P. Lyons, A. (ed) *Qualitative research in clinical and health psychology*. United Kingdom: MacMillan.

Braun, V. and Clarke, V. (2014). What can thematic analysis offer health and well-being researchers?. *International Journal of Qualitative Studies on Health and Well-Being*, 9(26), 152-157.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3 (2)*, 77-101.

Braun, G., Kumm, S., Brown, C., Walte, S., Hughes, M., & Maggin, D. (2018). Living in Tier 2: Educators perceptions of MTSS in urban schools. *International Journal of Inclusive Education*, DOI: 1080/13603116.2018.1511758.

Bronfenbrenner, U. (1979) *The ecology of human development: Experiments by nature and design*, Cambridge MA: Harvard University Press.

Brown, J. & Isaacs, D (2005) *The World Café: Shaping our future through conversations that matter*, San Francisco, CA: Berrett-Koehler Publishers, Inc.

Buchorn, M. & Lynch, H. (2010). Perspectives regarding Occupational Therapy practice with children and families. *Journal of Occupational Therapy, Schools and Early Intervention*, 3, 105-112.

Bundy, A., Brentnall, J., Hemsley, B., & Marshall, E. (2008). *Therapy services in the disability sector: literature review*. NSW Department of Ageing, Disability, and Home Care.

Cahill, S. (2010). Contributions made by occupational therapists in RtI: A pilot study. *Journal of Occupational therapy, Schools and Early Intervention*, 3, 3-10.

Cahill, S., McGuire, B., Krumdick, N., & Lee, M. (2014). National survey of Occupational Therapy practitioners' involvement in Response to Intervention. *American Journal of Occupational Therapy, 68(6)*, 234-240.

Camden, C., Leger, F., Morel, J. & Missiuna, C. (2015). A service delivery model for children with DCD based on principles of best practice. *Physical & Occupational Therapy in Pediatrics*, 35, 412-425. DOI: 10.3109/01942638.2014.978932.

Campbell, W. N., Missiuna, C. A., Rivard, L. M. & Pollock, N. A. (2012). Support for everyone: Experiences of occupational therapists delivering a new model of school-based service. *Canadian Journal of Occupational therapy, 79*, 51-59.

Case-Smith, J., Holland, T., Lane, A., & White, S. (2012). Effect of a co-teaching handwriting program for first-graders: One-group pretest-posttest design. *American Journal of Occupational Therapy, 66*(4), DOI: 10.5014/ajot2012.004333.

Carroll, C., Murphy, G., Sixsmith, J. (2013). The progression of early intervention disability services in Ireland. Infants and Young Children, 26:17-27.

Case-Smith, J., Weaver, L., & Holland, T. (2014). Effects of a classroom-embedded occupational therapist-teacher handwriting program for first-grade students. *American Journal of Occupational Therapy, 68*(6), 390-398.

Centre for Early Childhood Development and Education (CECDE) (2006) Síolta, The national quality framework for early childhood education, Dublin: Centre for Early Childhood Development and Education. Retrieved from: http://siolta.ie/media/pdfs/siolta-manual-2017.pdf.

Chu, S. (2017). Supporting children with special educational needs (SEN): An introduction to a 3-tiered school-based occupational therapy model of service delivery in the United Kingdom. *World Federation of Occupational Therapists Bulletin*, 73:2, 107-116, DOI:10.1080/14473828.2017.1349235.

Citizens Information (n.d.) Psychological Services for Schools. Available at https://www.citizensinformation.ie/en/education/primary_and_post_primary_education/educational_supports/national_educational_psychological_service.html.

Clark, A. & Moss, P. (2011) Listening to young children: The mosaic approach, 2nd ed., Oxford.

Clarke, V., & Braun, V. (2017). Thematic analysis, *The Journal of Positive Psychology*, 12 (3), 297-298, DOI: 10.1080/17439760.2016.1262613.

Cohen, L., Manion, L. & Morrison, K. (2017) *Research methods in education*, 8th ed., London: Routledge.

Dahler-Larsen, P. (2018). Qualitative evaluation. Methods, ethics, and politics with stakeholders. N. K. Denzin and Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (5th ed.) pp. 867-886. London: Sage.

Daly, P., Ring, E., Egan, M., Fitzgerald, J., Griffin, C., Long, S., McCarthy, E., Moloney, M., O'Brien, T., O'Byrne, A., O'Sullivan, S., Ryan, M., Wall, E., Madden, R. & Gibbons, S. (2016) *An evaluation of education provision for students with autism spectrum disorder in Ireland*, Trim: National Council for Special Education.

D'Amour, D., Goulet, L., Labadie, J-F., Martín-Rodriguez, LS., & Pinealut, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Services Research* 8, 188.

Deloitte & Touche (2010). Review of school health support services: final report. Toronto, ON: Ministry of Health and Long-term care. Retrieved from: https://www.osla.on.ca/uploads/deloitte_shss_review_report.pdf.

Demonstration Project Working Group (2017) Report to the Cross-Sectoral team: Development of a Demonstration Model for In-School Therapy Services, December.

Demonstration Project Working Group (2018) Development of a Demonstration Model for In School and Early Years Therapy Services Progress Report, October.

Department of Children and Youth Affairs (2012) *Guidance for developing ethical research projects involving children*, Dublin: Department of Children and Youth Affairs.

Department of Children and Youth Affairs (2014) *Better outcomes, brighter futures: The national policy framework for children and young people 2014-2020*, Dublin: Department of Children and Youth Affairs. Retrieved from: https://www.dcya.gov.ie/documents/cypp_framework/BetterOutcomesBetterFutureReport.pdf.

Department of Education and Science (2007) Special Educational Needs: A Continuum of Support, Dublin: Department of Education and Skills, https://www.education.ie/en/Schools-Colleges/Services/National-Educational-Psychological-Service-NEPS-/neps_special_needs_guidelines.pdf.

Department of Education and Skills (2016) Action Plan for Education 2016-2019. Dublin: Department of Education and Skills.

Department of Education and Skills (2017a) Guidelines for Primary Schools: Supporting Pupils with Special Educational Needs in Mainstream Schools, Dublin: Department of Education and Skills, https://www.education.ie/en/The-Education-System/Special-Education/Guidelines-for-Primary-Schools-Supporting-Pupils-with-Special-Educational-Needs-in-Mainstream-Schools.pdf.

Department of Education and Skills (2017b) Guidelines for Post-Primary Schools: Supporting Students with Special Educational Needs in Mainstream Schools, Dublin: Department of Education and Skills, https://www.education.ie/en/The-Education-System/Special-Education/Guidelines-for-Post-Primary-Schools-Supporting-Students-with-Special-Educational-Needs-in-Mainstream-Schools.pdf.

Department of Education and Skills (2019a) Circular to the management authorities of all mainstream primary schools. Special education teaching allocation, Dublin: Department of Education and Skills. Retrieved from: https://www.education.ie/en/Circulars-and-Forms/Active-Circulars/cl0007_2019.pdf.

Department of Education and Skills (2019b) Circular to the management authorities of all post primary schools: Secondary, community and comprehensive schools and chief executive officers of the education and training boards, Dublin: Department of Education and Skills. Retrieved from: https://www.education.ie/en/Circulars-and-Forms/Active-Circulars/cl0008_2019.pdf.

Department of Health and Children (2001). Primary Care A New Direction Quality and Fairness – A Health System for You: Health Strategy. Accessed https://health.gov.ie/wp-content/uploads/2014/03/primcare-report.pdf.

Desforges, M. & Lindsay, G. (2010) *Procedures used to diagnose a disability and to assess special educational needs: An international review*, Trim: National Council for Special Education. Retrieved from: https://ncse.ie/wpcontent/uploads/2014/10/5_NCSE_Diag_Ass.pdf.

Dunn (2011). Best practice occupational therapy for children and families in community settings (2nd ed.). Thorofare, NJ: SLACK.

Eadie, P., Stark, H., & Niklas, F. (2019). Quality of Interactions by Early Childhood Educators Following a Language-Specific Professional Learning Program. *Early Childhood Education Journal*, 47(3), 251-263. http://doi.org/10.1007/s10643–019–00929–5.

Ebbels, S. (2014). Effectiveness of intervention for grammar in school-aged children with primary language impairments: A review of the evidence. *Child Language Teaching and Therapy, 30*, 7-40.

Ebbels, S.H., McCartney, E., Slonims, V. Dockrell, J.E. & Norbury, C.F. (2019). Evidence-based pathways to intervention for children with language disorders. *International Journal of Language and Communication Disorders, 54*(1), 3-19.

Englander, M. (2012). The Interview: Data collection in descriptive phenomenological human scientific research. *Journal of Phenomenological Psychology*, 43 (13) 11-21.

European Agency for Special Needs and Inclusive Education (EASNIE) (2017a) *Inclusive early childhood education: New insights and tools – Contributions from a European study*. Odense, Denmark. Retrieved from: https://www.european-agency.org/sites/default/files/IECE_Synthesis_Report_2017.pdf.

European Agency for Special Needs and Inclusive Education (EASNIE) (2017b) Inclusive early childhood education self-reflection tool. Odense, Denmark. Retrieved from: https://www.european-agency.org/resources/publications/inclusive-early-childhood-education-environment-self-reflection-tool.

Fitzgerald, B., & MacCobb, S. (2017). An occupational therapy and teaching partnership: Applying a scholarship of practice model. *Occupational Therapy in Health Care*. DOI: 10.1080/07380577.2017.1342888

Fricke, S., Bowyer-Crane, C. A., Haley, A. J., Hulme, C. & Snowling, M. (2013). Efficacy of language intervention in the early years. *Journal of Child Psychology and Psychiatry*, **54**, 280-290.

Fricke, S., Burgoyne, K., Bowyer-Crane, C., Kyriacou, M., Zosimidou, A., Maxwell, L., et al. (2017). The efficacy of early language intervention in mainstream school settings: a randomized controlled trial. *Journal of Child Psychology and Psychiatry*, 58(10), 1141-1151. http://doi.org/10.1111/jcpp.12737.

Gallagher, A., Murphy, C., Conway, P., & Perry, A. (2019). Engaging multiple stakeholders to improve speech and language therapy services in schools: An appreciative inquiry-based study. *BMC Health Services Research 19, 226-235*.

Gersten, R., Compton, D., Connor, C. M., Dimino, J., Santoro, L., Linan-Thompson, S., & Tilly, W. D. (2008). Assisting students struggling with reading: Response to Intervention and multi-tier intervention for reading in the primary grades. A practice guide (NCEE 2009-4045). Washington, DC: National Center for Education Evaluation and Regional Assistance, Institute of Education Sciences, U.S. Department of Education. Retrieved from https://ies.ed.gov/ncee/wwc/docs/practiceguide/rti_reading_pg_021809.pdf.

Government of Ireland. (2018a). *A whole-of-government strategy for babies, young children and their families 2019-2028*. Dublin: Government Publications Office. Retrieved from: https://www.dcya.gov.ie/documents/earlyyears/19112018_4966_DCYA_EarlyYears_Booklet_A4_v22_WEB.pdf.

Government of Ireland. (2018b) *First five: Report on the national consultation with young children*, Dublin: Department of Children and Youth Affairs. Retrieved from: https://www.dcya.gov.ie/documents/earlyyears/19112018_5033_DCYA_EarlyYears_Report__Web.pdf.

Government of Ireland (2019) A programme for a partnership government, Dublin: Government of Ireland. Retrieved from: https://www.merrionstreet.ie/MerrionStreet/en/ImageLibrary/Programme_for_Partnership_Government.pdf.

Grindal, T., Bowne, J.B. Yoshikawa, H., Schindler, H.S. Duncan, G.J. Magnuson, K. & Shonkoff, J.P. (2016). The added impact of parenting education in early childhood education programs; A meta-analysis. *Children and Youth Services Review, 70*, 238-249.

Grogg, K., Meyers, A. B., & and Meyers, J. (2017). Prevention through consultation: A model to guide future developments in the field of school psychology. The Future of School Psychology Conference (pp. 257-276). Routledge.

Guralnick, M. & Bruder, M. (2016). Early childhood inclusion in the United States. *Infants & Young Children*, 29(3), 166-177,

Haley, A., Hulme, C., Bowyer-Crane, C., Snowling, M. J., & Fricke, S. (2016). Oral language skills intervention in pre-school-a cautionary tale. *International Journal of Language & Communication Disorders*, *52*(1), 71-79.

Handley-More, D., Hollenbeck, J., Orentlicher, M., & Wall, E. (2013). Education reform Initiatives and school-based practice. *Special Interest Section: Early Intervention and Schools*, 20(3), 1-4.

Hanft & Shepherd. (2008). *Collaborating for student success*. Bethesda, MD: American Occupational Therapy Association.

Hargreaves, A.T., Nakhooda, R., Mottay, B., & Subramoney, S. (2012). The collaborative relationship between teachers and occupational therapists in junior primary mainstream schools. *South African Journal of Occupational Therapy*, 42(1), 7-10.

Hasson, N, & Botting, N (2010) Dynamic assessment of children with language impairments: A pilot study, *Child Language Teaching and Therapy*, 26 (3), pp 249-272.

Hayes, N., Keegan, S., & Goulding, E. (2012) Evaluation of the Speech and Language Therapy Service of Tallaght West Childhood Development Initiative. Dublin: Childhood Development Initiative (CDI).

Hayes. N. & Irwin. J. (2016). Listen up: Reflections on the CDI and HSE Speech and Language Services in Tallaght West. Dublin: Childhood Development Initiative (CDI).

Henefer, J. (2010). A research study of 36 behaviour support classrooms. Navan: National Behaviour Support Service.

Hicks, P., Solomon, Y., Mintz, J., Matziari, A., Ó Murchú, F., Hall, K., et al. (2018). *Initial teacher education for inclusion: Phase 1 and 2 report*. Trim, National Council for Special Education. Retrieved from: http://ncse.ie/wp-content/uploads/2018/09/NCSE-Teacher-Education-Inclusion-Phase1–2-RR26-for-webupload.pdf.

Hillier S, Civetta L, Pridham, L. (2010). A Systematic review of collaborative models for health and education professionals working in school settings and implications for training. *Education for Health*, 23(3), 393-405.

Hutchinson, J., & Clegg, J. (2011). Education practitioner-led intervention to facilitate language learning in young children: An effectiveness study. *Child Language Teaching and Therapy*, 27(2), 151-164. http://doi.org/10.1177/0265659010397232.

Hutton, E. (2009). Occupational therapy in mainstream primary schools: An evaluation of a pilot project. *British Journal of Occupational Therapy*, 72, 308-313.

Hutton, E., Tuppeny, S. & Hasselbusch, A. (2016). Making a case for universal and targeted children's occupational therapy in the United Kingdom. *British Journal of Occupational Therapy*, 79(7), 450-453.

Inter-Departmental Group (2015) *Supporting access to the Early Childhood Care and Education programme for children with a disability*, Retrieved from: http://nda.ie/nda-files/Supporting-Access-to-the-Early-Childhood-Care-and-Education-for-Children-with-a-Disability.pdf.

Jiang, H., & Logan, J. (2019). Improving Reading Comprehension in the Primary Grades: Mediated Effects of a Language-Focused Classroom Intervention. *Journal of Speech Language and Hearing Research, 62*(8), 2812-2828. http://doi.org/10.1044/2019_JSLHR-L-19–0015.

Jimerson, S. R., Burns, M. K., and& Van Der Heyden, A. M. (Eds.). (2015). Handbook of response to intervention: The science and practice of multi-tiered systems of support. Springer.

Johnson, B. & Christensen, L. (2017) Educational research: Quantitative, qualitative, and mixed approaches, 6th ed., Thousand Oaks, CA: Sage.

Justice, L.M. (2018). Conceptualising "dose" in paediatric language interventions: Current findings and future directions. *International Journal of Speech-Language Pathology, 20*(3), 1-6. http://doi.org/10.1080/17549507.2018.1454985.

Justice, L. M., Logan, J., Jiang, H., & Schmitt, M. B. (2017). Algorithm-driven dosage decisions (AD 3): Optimizing treatment for children with Language Impairment. *American Journal of Speech-Language Pathology, 26*(1), 57-68. http://doi.org/10.1044/2016_AJSLP-15–0058.

Kennedy, J., Missiuna, C., Pollock, N., Wu, S., Yost, J. & Campbell, W (2018). A scoping review to explorer how universal design for learning is described and implemented by rehabilitation health professionals in school settings. *Child Care, Health and Development*, 44, 670-688.

Lathouras, M., Westerveld, M., & Trembath, D. (2019). Longitudinal reading outcomes in response to a book-based, whole-class intervention for students from diverse cultural, linguistic and socioeconomic backgrounds. *Australian Journal of Learning Difficulties*, 00(00), 1-15. http://doi.org/10.1080/19404158.2019.1640755.

Law M, Darrah J,Pollock N, Wilson B, Russell D, Walter S, Rosenbaum P, & Galuppi B (2011) Focus on function: a cluseter randomised control trial comparing child versus context-focused intervention for young children with cerebral palsy. *Developmental and Child Neurology*, 53, 621-629.

Lee, W., & Pring, T. (2016). Supporting language in schools: Evaluating an intervention for children with delayed language in the early school years. *Child Language Teaching and Therapy*, 32(2), 135-146.

Leigers, K., Myers, C., & Schneck, C. (2016). Social participation in schools: A survey of occupational therapy practitioners. *American Journal of Occupational Therapy, 70 (5)*, 1-9.

Lidz, C. (1991). *Practitioner's guide to dynamic assessment*. New York: Guilford Press

Lincoln., Y. & Guba, E. (1985). *Naturalistic inquiry*, Beverley Hills, CA: Sage.

Lonigan, C., & Phillips, B.(2016) Response to instruction in preschool: Results of two randomised studies with children at significant risk of reading difficulties. *Journal of Educational Psychology, 108*, 114-129.

Lowe, H., Henry, L., Muller-, L., & Joffee, V. (2018). Vocabulary intervention for adolescents with language disorder: A systematic review. *International Journal of Language and Communication Disorders, 53*, 199-217.

Lynch, H. (2003) The development of a community paediatric programme for Occupational Therapists. [Oral Presentation], Annual Irish Occupational Therapy Conference, Killarney, Ireland, 1 April 2003.

MacCobb, S., Fitzgerald, B., and& Lanigan-O'Keeffe, C. (2014). The Alert Program for self-management of behaviour in second level schools: results of phase 1 of a pilot study. *Emotional and Behavioural Difficulties*, 19(4), pp.410-425.

McCartney, E. (1999). Barriers to collaboration: an analysis of systemic barriers to collaboration between teachers and speech and language therapists. *International Journal of Language and Communication Disorders*, 34(4), 431-440.

McCartney, E., Boyle, J., Ellis, S., Bannatyne, S., & Turnbull, M. (2011). Indirect language therapy for children with persistent language impairment in mainstream primary schools: Outcomes from a cohort intervention. *International Journal of Language and Communication Disorders, 46*, 76-82.

McKean, C., Law, J., Laing, K., Cockerill, M., Allon-Smith, J, McCartney, E., & Forbes, J. (2017). A qualitative case study in the social capital of co-professional collaborative co-practice for children with speech, language and communication needs. *International Journal of Language and Communication Disorders, 52*(4), 514-527.

Markham, A.N. (2018). Ethnography in the digital internet era: From fields to flows, descriptions to interventions. in N. K. Denzin and Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (5th ed.), London: Sage, 650-668.

Markussen-Brown, J., Juhl, C., Piasta, B., Bleses, D., Hojen, A., & Justice, L.M. (2017). The effects of language and literacy-focused professional development on early educators and children: A best-evidence meta-analysis. *Early Childhood Research Quarterly, 38*, 97-1.

Mecrow, C., Beckwith, J. & Klee, T. (2010). An exploratory trial of the effectiveness of an enhanced consultative approach to delivering speech and language intervention ins schools. *International Journal of Language and Communication Disorders 45*, 354-367.

Merriam, S. (2009) Qualitative research: A guide to design and implementation-Revised and expanded from qualitative research and case study applications in education, San Francisco, CA: Jossey-Bass.

Merriam, S. & Tisdall, E. (2007) *Qualitative research. A guide to design and implementation*, 4th ed., San Francisco, CA: Jossey-Bass.

Missiuna, C., Pollock, N., Levac, D., Campbell, W., Sahagian Whalen, S., Bennett, S., Hecimovich, C., Gaines, R., Cairney, J. & J. Russell, J. (2012). Partnering for Change: An innovative school-based occupational therapy service delivery model for children with developmental coordination disorder. *Canadian Journal of Occupational therapy, 79*: 41-50.

Missiuna, C., Hecimovich, C., Dix, L., Campbell, W., Pollock, N., Bennett, S., Canden, C., DeCola, C., McCauley, D Gaines, R., Cairney, J., & Stewart D. (2015). *Partnering for Change: Implementation and Evaluation Final Report, 2013-2015: Final Report for the Ontario Ministry of Health and Long Term Care and the Ontario Ministry of Education*. Hamilton, ON: CanChild, McMaster University. Available at www.partneringforchange.ca.

Missiuna, C., Pollock, N., Campbell, W., DeCola, C.,Hecimovich, C., Sahagian Whalen5, S., Siemon, J.,Song, K., Gaines, R., Bennett, S., McCauley, D., Stewart, D., Cairney, J., Dix, L & Camden, C. (2017). Using an innovative model of service delivery to identify children who are struggling in school. *British Journal of Occupational Therapy, 80*(3) 145-154.

Mukherji, P. & Albon, D. (2018) Research methods in early childhood: An introductory guide, London: Sage.

Murawski, W. & Hughes, C (2009). Response to Intervention, collaboration, and co-teaching: A logical combination for successful systemic change. *Preventing School Failure*, 53, 4, 267-277.

Murphy, A., Franklin, S., Breen, A., Hanlon, M., McNamara, A., Bogue, A. & James, E. (2017). A whole class teaching approach to improve vocabulary skills of adolescents attending mainstream secondary school in areas of socioeconomic disadvantage. *Child Language Teaching and Therapy*, 33(2), pp.129-144.

National Center on Response to Intervention (2011). *RTI Scheduling Processes for Middle Schools*. Washington, DC: U.S. Department of Education, Office of Special Education Programs, National Center on Response to Intervention. July.

National Behaviour Support Service. (2014a). NBSS Level 3 Support: The Principals' Viewpoint. Navan: National Behaviour Support Service.

National Behaviour Support Service. (2014b). NBSS Level 3 Support: The Behaviour Support Teachers' Views. Navan: National Behaviour Support Service.

National Behaviour Support Service. (2014c). NBSS Level 3 Support: The Students' Voice. Navan: National Behaviour Support Service.

National Council for Curriculum and Assessment (1999) *Primary school curriculum. Introduction*, Dublin: National Council for Curriculum and Assessment.

National Council for Curriculum and Assessment (2009) *Aistear: The early childhood curriculum framework*, Dublin: National Council for Curriculum and Assessment.

National Council for Special Education (2011) *Inclusive education framework*, Trim National Council for Special Education. Retrieved from: http://ncse.ie/wp-content/uploads/2014/10/InclusiveEducationFramework_InteractiveVersion.pdf.

National Council for Special Education (2014) *Delivery for students with special educational needs: a better and more equitable way*, Trim, National Council for Special Education.

National Council for Special Education (2017). *Delivering for students with additional care needs: the right support at the right time in schools*. Trim, National Council for Special Education. Available at https://ncse.ie/wp-content/uploads/2018/05/NCSE-Delivering-Students-Care-WGR02.pdf.

National Council for Special Education (2018) Request for Tenders to conduct an evaluation of In-school and Pre-school Therapy Support Demonstration Project.Trim: National Council for Special Education.

National Council for Special Education (2018). Comprehensive Review of the Special Needs' Assistant Scheme: A New School Inclusion Model to Deliver the Right Supports at the Rights Time to Students with Additional Care Needs. Trim, National Council for Special Education.

NEPS (National Educational Psychological Service) (2007) Behavioural, Emotional and Social Difficulties: a Continuum of Support. Available at https://www.education.ie/en/Schools-Colleges/Services/National-Educational-Psychological-Service-NEPS-/neps_besd_continuum_teacher_guide.pdf.

NEPS (National Educational Psychological Service) (n.d.) Information for Parents. Available at https://www.gov.ie/en/service/a6cef6-neps-information-for-parents/.

National Reference Group on Multidisciplinary Disability Services for Children aged 5 to 18 years (2009). Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5 to 18 years. Available at https://www.hse.ie/eng/services/publications/disability/report%20of%20the%20national%20reference%20group%20on%20multidisciplinary%20disability%20services%20for%20children%20aged%205-18.pdf.

Neuman, S., Newman, E. & Dwyer, J. (2011). Educational effects of a vocabulary intervention on pre-schoolers' word knowledge and conceptual development: A cluster randomised trial. *Reading Research Quarterly, 46*, 249-272.

Nugent, M. (2010). Teaching our Traveller children to read: An action research project. Support for Learning, 25(2), 55-62.

Nugent, M. & Devenney, P. (2008). Cross-age peer reading in a secondary school: An evaluation. Journal of the Irish Learning Support Association, 30, 83-90.

Nugent, M., Jones, V., McElroy, D., Peelo, M., Thornton, T. and, & and Tierney, T. (2014). Consulting with groups of teachers. Evaluation of a pilot project in Ireland. Educational Psychology in Practice, 30(3), 255-271.

Novak, I. (2014). Evidence to practice commentary: new evidence in coaching interventions. *Physical & Occupational Therapy in Pediatrics, 34(2)*, 132-137.

Oakes, W., Lane, K., Jenkins, A., & Booker, B. (2013). Three-tiered models of prevention: Teacher efficacy and burnout. *Education and Treatment of Children*, 36, (4), 95-126.

O'Connor, R., Bocian, K., Sanchez, V., & Beach, K. (2014). Access to a Responsiveness to Intervention model: Does beginning Intervention in kindergarten matter? *Journal of Learning Disabilities, 47*(4) 307-328.

Odom, S., Duda, M., Kucharczyk, S., Cox, A., & Stabel, A. (2014). Applying an Implementation science framework for adoption of a comprehensive program for high school students with Autism Spectrum Disorder. *Remedial and Special Education*, 35(2) 123-132.

Ohl, A, Grace, H., Weber, K., Kenny, S., Salvatore, C. & Wagreich, S. (2013). Effectiveness of a 10-week Tier-1 Response to Intervention program in improving fine-motor and visual-motor skills in general education kindergarten students. *American Journal of Occupational Therapy*, 67, 507-514.

Olsen, J. (2003). *Handwriting Without Tears*. 9th ed. Potomac, MD: Author.

Pameijer, N. (2006) Towards needs-based assessment: Bridging the gap between assessment and practice. Educational &and Child Psychology, 23 (3).

Patton, S., Hutton, E., & MacCobb, S. (2015). Curriculum differentiation for handwriting and occupational therapy/teacher partnership: Collaboration or conflict? *Irish Educational Studies, 34*(2), 107-124.

Peräkylä, A, & Ruusuvori, J. (2018). Analyzing talk and text. In N. K. Denzin, & Y. S. Lincoln, (Eds.). *The sage handbook of qualitative research*, 5th ed. London: Sage, pp 670-690.

Pollock, N., Dix, L., Whalen,S., Campbell, W. & Missiuna, C.(2017). Supporting occupational therapists implementing a capacity-building model in schools. *Canadian Journal of Occupational Therapy*, 1-11, DOI: 10.1177/0008417417709483.

Praeger. A. Ring, E. & O'Sullivan, L. (2016). The importance of including the child's voice in the transition process: Signposts from a national evaluation of concepts of school readiness in Ireland. *Children's Research Digest*, Vol. 2(3), 37-44.

Progressing Disability Services for children and young people (2013). *Education and Health Working Group Framework for Collaborative Working between Education and Health Professionals*. Retrieved from: https://www.hse.ie/eng/services/list/4/disability/progressing-disability/education-and-health-framework-for-collaborative-working.pdf.

Progressing Disability Services for children and young people (2016). *Access to Services for Children and Young People with Disability and Developmental Delay*. Retrieved from: https://www.hse.ie/eng/services/list/4/disability/progressing-disability/national-access-policy-for-children-with-disability-development-delay.pdf.

Ram, G Marinellie, S.A., Benigno,J and McCarthy, J. (2013). Morphological Analysis in Context Versus Isolation: Use of a Dynamic Assessment Task with School-Age Children. Language, Speech and Hearing Services in School, 44, 32-47.

Reeder, D., Arnold, S., Jeffries, L., & McEwen, I. (2011). The role of Occupational Therapists and Physical Therapists in elementary school system, early Intervening services and response to intervention: A case report. *Physical & Occupational Therapy in Pediatrics*, 31:1, 44-57.

Rens, L., & Joosten, A. (2014). Investigating the experiences in a school-based occupational therapy program to inform community-based paediatric occupational therapy practice. *Australian Occupational Therapy Journal*, 61148-158.

Ring, E. & O'Sullivan, L. (2016). The importance of including the child's voice in the transition process: Signposts from a national evaluation of concepts of school readiness in Ireland. *Children's Research Digest*, Vol. 2(3), 37-44.

Ring, E., O'Sullivan, L., Ryan, M. and Burke, P. (2018) A melange or a mosaic of theories? How theoretical perspectives on children's learning and development can inform a responsive pedagogy in a redeveloped primary school curriculum, Dublin: National Council for Curriculum and Assessment. Retrieved from: https://www.ncca.ie/media/3863/seminar_four_er_los_mr_pb_paper.pdf.

Ring, E., O'Sullivan, L. & Ryan, M. (2019). Early childhood teacher-as-researcher: An imperative in the age of "schoolification": Harnessing Dewey's concept of the laboratory school to disrupt the emerging global quality crisis in early childhood education. In O. Saracho, (Ed.), *Contemporary perspectives on research in laboratory schools in early childhood education*, Charlotte, NC: Information Age Publishing.

Ring, E., O'Sullivan, L., Ryan, M. & Daly, P. eds. (2020). *Leading Inclusion from the Inside Out: A Handbook for Parents and Early Childhood Teachers in Early Learning and Care, Primary and Special School Settings*. Oxford: Peter Lang [In preparation].

Roberts, M. & Kaiser, A. (2011). The effectiveness of parent-implemented language interventions: A meta-analysis. *American Journal of Speech-Language Pathology, 20*, 180-199.

Rose, R. (2010). Understanding inclusion: Interpretations, perspectives and culture. In R. Rose, (Ed.), *Confronting obstacles to inclusion'*, London: Routledge, pp 1-6.

Roulstone S.E., Marshall J.E., Powell G.G., Goldbart J, Wren Y.E., Coad J, (2015) Evidence-based intervention for preschool children with primary speech and language impairments: Child Talk – an exploratory mixed-methods study. Programme Grants Appl Res;3(5).

RCSLT (Royal College of Speech and Language Therapy) (2011). Guidance on quality standards for local authorities and schools as commissioners of speech and language therapy services in the UK. Retrieved from https://www.rcslt.org/speech-and-language-therapy.

RSM (2019) An End of Year One Review of the Access and Inclusion Model (AIM): Final Report. Available at https://aim.gov.ie/wp-content/uploads/2019/10/aim-end-of-year-one-review.pdf.

Ruttledge, R., Devitt, E., Greene, G., Mullany, M., Charles, E., Frehill, J. Moriarty, M. (2016). An evaluation of the FRIENDS for Life emotional resilience programme for children: delivered by teachers in primary schools. *Educational and Child Psychology, 33*(2), 69-89.

Sanetti, L. (2015). Data-driven delivery of implementation supports in a multi-tiered framework: A pilot study. *Psychology in the Schools*, Vol. 52(8). DOI: 10.1002/pits.21861

Schmitt, M. B., Justice, L. M., & Logan, J. A. R. (2016). Intensity of language treatment: contribution to children's language outcomes. *International Journal of Language & Communication Disorders*, 52(2), 155-167.

Shaw, I., Greene, J.C. & Mark, M.M. (2006). Handbook of evaluation: Publications, policies, programs and practices. London: Sage.

Simmons Carlsson, C., Hocking, C. & Wright-St Clair, V. (2007). The 'why' of who we are. Exploring the 'culture of practice' of Ministry of Education Special Education occupational therapists and physiotherapists. *Kairaranga*, 8(2), 6-14.

Smith-Lock, K., Leitao, S., Lambert, L., Prior, P., Dunn, A., Cronje, J., et al. (2013). Daily or weekly? The role of treatment frequency in the effectiveness of grammar treatment for children with specific language impairment. *International Journal of Speech-Language Pathology*, 15(3), 255-267.

Starling, J., Munro, N., Togher, L., & Arcuili, J. (2012). Training secondary school teachers in instructional language modification techniques to support adolescents with language impairment: A randomized controlled trial. *Language, Speech, and Hearing Services in Schools*, 43, 474-495.

Strogilos, V., Lacey, P., Xanthacou, Y., & Kaila, M. (2011). Collaboration and integration of services in Greek special schools: two different models of delivering school services. *International Journal of Inclusive Education, 15(8)*, 797-818.

SurveyMonkey Inc. (2018) SurveyMonkey, Palo Alto, CA: SurveyMonkey Inc. Retrieved from: https://www.surveymonkey.com/welcome/sem/?iv_=__iv_p_1_a_1402109519_g_53976640783_c_291931112150_k_survey-monkey_m_e_w_kwd-321305555933_n_g_d_c_.

The Individuals with Disabilities Education Improvement Act of 2004. USA. Retrieved from https://sites.ed.gov/idea/.

Timmons, V. & Wagner, M. (2009). Inclusive education knowledge exchange initiative: An analysis of the Statistics Canada Participation and Activity Limitation survey. Retrieved from: http://en.copian.ca/library/research/ccl/inclusive_edu_know/inclusive_edu_know.pdf.

Tosh, R., Arnott, W., & Scarinci, N. (2017). Parent-implemented home therapy programmes for speech and language: A systematic review. *International Journal of Language and Communication Disorders, 52*, 253-269.

Turner, S., Ring, E. & O'Sullivan, L. (2020). The transformative power of student voice for learning and teaching: Findings from research in a primary school in Ireland. *Learn*, 40, 7-17.

United Nations (1989) *United Nations convention on the rights of the child*. Retrieved from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

UNESCO (United Nations Educational, Scientific and Cultural Organisation) (2005) Guidelines for inclusion: Ensuring access to education for all, Paris, United Nations Educational, Scientific and Cultural Organisation. Retrieved from: http://www.ibe.unesco.org/sites/default/files/Guidelines_for_Inclusion_UNESCO_2006.pdf.

Vadasy, P., Sanders, E., & Logan Herrera, B. (2015) Efficacy of rich vocabulary instruction in fourth and fifth-grade classrooms. *Journal of Research on Educational Effectiveness 8*, 325-365.

Van Oers, B. (2003). Learning resources in the context of play. Promoting effective learning in early childhood. *European Early Childhood Education Research Journal*, 11(1), 7-6.

Villeneuve, M. (2009). A critical examination of school-based occupational therapy collaborative consultation. *Canadian Journal of Occupational Therapy, 76*, 206-218.

Villeneuve, M., & Shulha, L. (2012). Learning together for effective collaboration in school-based occupational therapy practice. *Canadian Journal of Occupational Therapy, 79*, 293-302.

White, S., & Spenser, S. (2018). A school-commissioned model of speech and language therapy. *Child Language Teaching and Therapy, 34*(2), 141-153.

White, R., Prager, E., Schaefer, C., Kross, E., Duckworth, A., & Carlson, S. (2016) 'The "batman effect": Improving perseverance in young children', *Childhood Development*, 88(5), 1563-1571.

Wilson, A. & Harris, R. (2018) Collaborative occupational therapy: Teachers' impressions of the Partnering for Change (P4C) Model, *Physical & Occupational Therapy in Pediatrics*, 38:2, 130-142.

Winter, E. & O' Raw, P. (2010). Literature review of the principles and practices relating to inclusive education for children with special educational needs. Meath: National Council for Special Education.

Workload model statement jointly developed by the American Occupational therapy Association and the Speech, Language, Hearing Association. Retrieved from: https://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf.

World Café Community Foundation (2015) *A quick reference guide for hosting World Café*, Greenbrae, CA: The World Café Community Foundation. Retrieved from: http://www.theworldcafe.com/wp-content/uploads/2015/07/Cafe-To-Go-Revised.pdf.

WHO (World Health Organisation) (2011). *Education world report on disability*. World Health Organisation. Retrieved from https://www.who.int/disabilities/world_report/2011/report.pdf.

Yin, R.K. (2014) Case study research: Design and methods-applied social research methods, 5th ed., London: Sage.

Appendices

Appendix A: Aims of Demonstration Project and the Background Context

Appendix B: Outcomes of P4C

Appendix C: Evidence of Effectiveness and Characteristics of the Tiered Model of School-Based Therapy Practice

Appendix D: Frameworks for Support to Schools/Early Learning

Appendix E: Overview of the Range of Documentation Examined

Appendix F: Online Questionnaire Example

Appendix G: World Café Processes

Appendix H: Sample Interview Transcripts

Appendix I: Information Letters and Consent/Assent Forms

Appendix J: Project Plans for this Demonstration Project

Appendix A: Aims of Demonstration Project

The aims of the Demonstration Project are sub-divided into aims for ELC settings and aims for schools. The division appears to reflect the unique nature of ELC settings and schools.

Early Learning and Care Settings[79]

- To develop and evaluate a multi-tiered continuum-of-support therapy model which aims to build capacity and inclusion in educational settings
- To support the learning, engagement and participation of all children by facilitating access to all aspects of the curriculum in Early Learning and Care settings
- To explore and develop effective models of collaborative partnership between in-setting project therapists, Early Learning and Care staff, the Department of Children and Youth Affairs, the Department of Education and Skills and the Department of Health and HSE Services with a view to achieving better educational outcomes for children and their families
- To explore and develop models of effective cross-sectoral collaboration and pathways to ensure clarity of roles and optimal use of resources between in-setting therapists and therapists in statutory and non-statutory organisations

The Department of Children and Youth Affairs, using defined sampling criteria, randomly selected 75 Early Learning and Care settings, grouped into clusters of 5 pre-schools associated with mainstream schools, for participation in the project. Settings were invited to participate in the project on a voluntary basis[80].

Schools[81]

- To develop and evaluate a multi-tiered continuum-of-support therapy model which aims to build capacity and inclusion in educational settings
- To support the learning, engagement and participation of all students by facilitating access to all aspects of the curriculum for schools
- To explore and develop effective models of collaborative partnership between in-school project therapists, school staff, the Department of Education and Skills and the Department of Health and HSE Services with a view to achieving better educational outcomes for students and their families
- To explore and develop models of effective cross-sectoral collaboration and pathways to ensure clarity of roles and optimal use of resources between in-school therapists and therapists in statutory and non-statutory organisations

The Educational Research Centre, according to defined sampling criteria, randomly selected 75 schools for participation in the project. Schools were been invited to participate in the project on a voluntary basis.

79 Early Learning and Care settings is the terminology used by the Demonstration Project. The Evaluation Team have chosen to use the term 'Early Learning and Care settings' to reflect current terminology.

80 Report to Cross Sectoral Team, October 2018.

81 The term 'schools' include primary schools, post-primary schools and special schools.

Appendix B: P4C Outcomes

Table 1: P4C Outcomes

P4C model was established 2008, piloted 2009, Demonstration Project 2011-2012 and evaluated in 2015.

Outcomes for children included:

- far more children reached by Occupational Therapy, than is possible in a traditional model
- earlier identification of children with special needs, including seldom-heard children from disadvantaged communities
- identification of children's needs at a younger age
- children's ability to participate more independently improved across the school year
- children were seen more frequently each year than would be typical in traditional services – the right support at the right time
- reduced wait-list times.

Outcomes for school staff included:

- educators capacity increased across the years of the study
- majority of parents found P4C beneficial
- reaching parents continued to be a challenge throughout
- P4C model led to a decrease in documentation and paperwork to process and deal with intensive Tier 3 tasks compared to referrals to other services.

P4C programme has been shown to be effective at reducing waitlists and increasing generalisability (Camden et al, 2015).

Appendix C: Evidence of Effectiveness for Each Tier, and Characteristics of the Tiered Model of School-Based Therapy Practice

Tier 1 Evidence and Outcomes

The evidence for Tier 1 interventions in Occupational Therapy includes successful provision of training and ongoing screening and support, particularly at pre-school and primary school levels. Examples of this are universal screening, progress monitoring, consultations regarding classroom design and modifications for all students (e.g. Bissell and Cermak, 2015; Ohl et al., 2013). In Ohl et al.'s (2013) study of a Tier 1 fine-motor handwriting intervention, Occupational Therapists worked collaboratively with teachers on a **weekly basis** for ten weeks to deliver this intervention. While there were significant outcomes for motor skills, the effect size was small, which may be due to the short intervention time for the programme. However, an unexpected outcome was that the educators continued to benefit from the collaboration beyond the project, which demonstrates the capacity building effect also of working collaboratively. For Speech and Language Therapy, the evidence for Tier 1 intervention occur following a successful provision of training and ongoing support particularly at pre-school and primary school level around the identification of children with language disorder and the relationship between speech, language and communication skills and the development of literacy skills. Positive effects (ranging from small to large) have been found in the vocabulary of children who received teacher-delivered programmes compared to control children. Interventions involved daily instructions with lesson-plans embedded in the curriculum. Similarly, positive effects on cognition, language and pre-academic skills for parent-mediated interventions for pre-school children where coaching and home visits were involved (Vadasy, Sanders and Logan Herrera, 2015; Apthorp et al., 2012). Furthermore, a large randomised controlled trial (from children in 160 classrooms) showed that language-focused interventions positively impact students proximal language outcomes (those directly related to the intervention) but also had large effects on distal reading comprehension measures (Jiang and Logan, 2019). Another randomised controlled trial also reported evidence of teacher-related outcomes such as increased knowledge and capacity(e.g. Starling et al., 2012). Finally, some large-scale cluster randomised controlled trials have found that classroom-based language programmes delivered by trained early educators or teachers can improve vocabulary and grammar in children, but that a high level of dosage is required for this to be achieved (Ebbels et al., 2019).

Evidence is scarce on the involvement of boards of management and principals in school-based therapy practice. In a review of universal design and rehabilitation professionals, evidence showed that school administrators need to understand the role of therapy professionals un UDL in order to maximise school-based practice at Tier 1 (Kennedy et al., 2018).

Finally, evidence in RtI Early Learning and Care settings shows that the relationship building and need for therapists to listen and learn from educators and co-production of resources is essential to embed interventions, where the therapist translates therapeutic interventions to educational ones (Blackwell and Dunn, 2016).

Tier 2 Evidence and Outcomes

The evidence in the literature from Tier 2 interventions in Occupational Therapy have identified significant improvements in emergent literacy outcomes and pre-writing in kindergarten children (ages 6-7 years) following seven months of embedded classroom Occupational Therapy, attending **2-days a week** providing a mixture of direct (36%) and indirect therapy (64%) (Bazyk et al., 2009). Evidence of effectiveness included impact on children with and without disabilities and those at risk of delays (Tier 2 and 3 combined).

Positive outcomes in legibility, speed of writing and fluency in first-grade children have also been found through the provision of a 12-week classroom-based co-teaching handwriting programme delivered jointly by educators and Occupational Therapists, USA (Case-Smith et al., 2014). Moreover, at-risk primary school children showed significant improvements in handwriting legibility compared to students receiving standard instruction, following a two-year co-taught, differentiated programme (Write Start) (Case-Smith, Weaver and Holland, 2014). From the Speech and Language Therapy literature at Tier 2, pre-school children with identified developmental delay had improved literacy and oral language after **eleven weeks of daily** small group intervention delivered by a trained teacher. Another study involved an RCT carried out in thirteen UK nursery schools which showed that **a fifteen-week language intervention programme** (delivered in small groups) had a positive impact on vocabulary knowledge but did not generalise to areas of language not targeted (Haley et al., 2014). Another study that involved delivery of the 'Let's Talk' programme (for eight weeks) with children with impoverished language skills in schools resulted in significant gains in expressive language (length and complexity of utterances) compared to controls, but no gain in receptive language (Hutchinson and Clegg, 2011). Similarly, an evaluation of the 'Talk Boost' intervention, which aimed to treat receptive and expressive language in early school years in areas of social deprivation, resulted in improvements in children who received the intervention (Lee and Pring, 2016). Randomised controlled trials in this field include one that investigated the effects of the Nuffield Early Language Intervention Programme in disadvantaged schools and pre-schools, where improvements in oral language skills compared to controls were found (Fricke et al., 2017). Two other randomised control studies in the US involving children with language difficulties who did not respond to Tier 1 interventions, found an improvement in the children's language following a pre-school intervention delivered in small groups of four children, with at least fifteen hours of intervention and **20 hours of educator training**) (Lonigan and Phillips, 2016).

Tier 3 Evidence and Outcomes

At Tier 3, the evidence for Occupational Therapy interventions includes a study of a delivering a collaborative handwriting school-based six-month programme for children with Down Syndrome where 17 out of 22 children improved in handwriting following delivery of the Handwriting Without Tears® programme, implemented by the teacher, guided by the Occupational Therapist (Patton, Hutton and McCobb, 2015). Another Occupational Therapy behavioural support programme composing of **20 daily sessions**, developed in Irish post-primary schools, involved a Movement Matters programme for intensive provision, resulting in

enhanced student social and emotional literacy skills and improved attention.[82] For Speech and Language Therapy, a randomised controlled trial noted positive outcomes found in a whole-class group of secondary school students with language impairments who were engaged in a modified language programme delivered by educators under the direction of a Speech and Language Therapist (Starling et al., 2012). Furthermore, a systematic review of thirteen studies on vocabulary interventions for adolescents found that individual, small group and whole-class interventions are all helpful (Loew et al., 2018). Two other systematic reviews with meta-analyses found that parent-mediated interventions have significant positive effects on receptive and expressive language of pre-school children with language impairments, although less so for those with intellectual disability. Furthermore, high dosages and coaching were required to see an effect (Ebbels et al, 2019). Recent findings question whether more is always better when treating children with language disorder. Empirical research suggests that spaced treatments may result in optimal gains for children. In addition, low frequency (e.g. **once a week**) can be beneficial provided that the dose (number of teaching episodes per session) is high (Justice, 2018).

Caseload versus Workload Models of School-Based Practice

A caseload refers to the number of children seen by a therapist or on their wait-list. In traditional practice, children are formally referred and the therapist places them on a wait-list for assessment or for intervention. In this way, waitlists are established and each child taken in turn according to priority need. The problem in a caseload approach is that children who have minor difficulties may rarely be seen in contrast to children with more significant needs. In a tiered approach, the opposite occurs: the therapist addresses the whole school first, then those at risk and finally those who need intensive intervention. In school settings, therapists do not use a caseload model of practice: rather, a workload model. In the **workload model**, the school is the client.[83] The concept of *workload* encompasses all of the work activities therapists perform that benefit students directly and indirectly, including activities directed towards groups of students, whole classrooms or school-wide populations (AOTA, 2011). This has been proven to maximise effectiveness in settings such as schools (Reeder et al., 2011). The change in thinking from a medical (caseload) approach to an educational (workload) approach was first introduced in the Speech and Language Pathology literature (ASHA, 2002; Annett, 2003), because of the need to acknowledge how therapists were spending their time. Equally, in Occupational Therapy the drive towards workload model emerged from US policy at the same time stemming from the No Child Left Behind (NCLB) (2002) legislation later replaced with the Every Student Succeeds Act (ESSA) in 2015. School-based therapists do not begin with direct intervention for a child, instead adopting a universal approach, whereby the therapist works with the school to support the inclusion and participation of all students, to the benefit of all, and especially for some who need it. From a workload perspective, this requires documenting all activities and tasks undertaken each day in the school. This can include meetings with teachers or parents, observations in

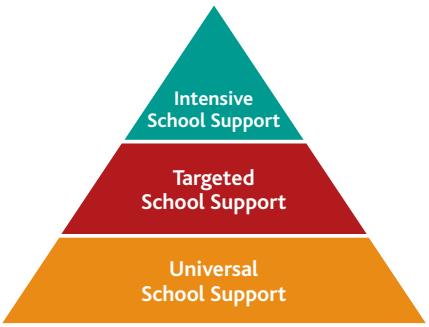
82 See overview of this and other examples of intensive interventions in an Irish context: Fitzgerald, B. and MacCobb, S. (2017). An occupational therapy and teaching partnership: Applying a scholarship of practice model. *Occupational Therapy in Health Care*. DOI: 10.1080/07380577.2017.1342888.

83 Workload model statement jointly developed by the American Occupational Therapy Association and the Speech, Language, Hearing Association, accessed https://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf.

classrooms, differentiated instruction, proposing ideas to address school and classroom needs, and shared problem-solving activities (AOTA, 2011). This approach depends on the development of shared establishment of overall goals, challenges and shared understanding of difficulties. From a strengths-based approach, the therapist shares knowledge with classroom staff and vice-versa, to capacity-build and jointly identify strategies to address a problem arising that relates to barriers to inclusion. By being in the classroom and school routinely, the therapist works from an informed position. The Occupational Therapists for example can conduct task analysis on-site of the physical and socio-cultural environment of the school to identify possible contributors to the problems and potential solutions. The Speech and Language Therapist can consult with teachers to meet the needs of students with a specific focus on the language underpinnings of learning and literacy.

Appendix D: Service Frameworks

Rialtas na hÉireann
Government of Ireland



Demonstration Project on In-School and Early Years Therapy

Support Project Therapy Support Project Actions

- Schools are required to participate in the research fieldwork and provide information as required pertaining to the evaluation of the Demonstration Project.
- Schools are responsible for informing parent(s)/guardian(s) about the Demonstration Project.
- For more information, please see the Occupational Therapy (OT) and Speech and Language Therapy (SLT) documentation on project supports.
- Adherence to child protection policy must take place in line with legislation.

Universal School Support	Targeted School Support	Intensive School Support
Who is involved? School management, school project team, school staff, parent(s)/ guardian(s), student(s), OT, SLT	**Who is involved?** School management, school project team, school staff, parent(s)/ guardian(s), student(s), relevant external agencies, OT, SLT	**Who is involved?** School management, school project team, school staff, parent(s)/guardian(s), student(s), relevant external agencies, OT, SLT
School: • to facilitate planning meetings with relevant staff and project OT/SLT during the academic year • to support the implementation of whole-school and classroom project targets in line with relevant school plans • to facilitate CPD/ learning activities for the whole staff and/or parent(s)/guardian(s) as agreed by the school project team and project OT/SLT.	**School:** • to facilitate collaboration between school staff and the project OT/SLT to identify students who require additional supports to those already provided at universal school support • to facilitate relevant school staff to work in partnership with the project OT/SLT to plan and implement agreed targeted supports • to monitor, review and document students' progress, in conjunction with the project OT/SLT • to inform parent(s)/ guardian(s) in relation to planned targeted support • to open/contribute to the student support file.	**School:** • to obtain informed written consent from parent(s)/ guardian(s) • to open/contribute to the student support file • to facilitate collaboration between school staff and the project OT/ SLT to identify students who require individualised support in the learning environment. this is in addition to the supports provided at the universal and targeted levels • to facilitate relevant school staff to work in partnership with the project OT/SLT to plan and implement agreed individualised supports • to monitor, review and document individual students' progress, in conjunction with the project OT/SLT.

Universal School Support	Targeted School Support	Intensive School Support
Who is involved? School management, school project team, school staff, parent(s)/guardian(s), student(s), OT, SLT	**Who is involved?** School management, school project team, school staff, parent(s)/guardian(s), student(s), relevant external agencies, OT, SLT	**Who is involved?** School management, school project team, school staff, parent(s)/guardian(s), student(s), relevant external agencies, OT, SLT
Project therapists: • to work with management and staff in reviewing current whole-school and classroom OT/SLT supports, as appropriate • to work with management and the school community in identifying, planning and implementing OT/SLT targets for whole-school and classroom support • to provide training and information to school staff and/or parent(s)/guardian(s) to support all students to participate to the best of their ability in the learning environment • to maintain appropriate records of support provided, in school and project office.	**Project therapists:** • to work in collaboration with school staff and parent(s)/guardian(s) in identifying and supporting groups of students with ongoing OT/SLT needs in the learning environment • to provide targeted support for teacher-led interventions, e.g. training, guidance on specific strategies/programmes, skills coaching, etc. • to review students' progress in collaboration with school staff and/or parent(s)/guardian(s) • to support teachers to update the student support file, as required • to maintain appropriate records of support provided, in school and project office.	**Project therapists:** • to ensure that informed written consent has been obtained from parent(s)/guardian(s) for intensive school support • to provide support and guidance on identifying students who have significant and persisting needs and require additional supports to those provided at the universal and targeted school support levels • to provide individualised OT/SLT recommendations and resources for integration into the school and home environments, in collaboration with school staff, parent(s)/guardian(s) and relevant external agencies • to provide support and guidance regarding referral to/liaison with external agencies, as required • to support teachers to update the student support file, as required • to maintain appropriate records of support provided, in school and project office.

Rialtas na hÉireann
Government of Ireland

Demonstration Project on In-School and Early Years Therapy Support Project Actions



- Early Years (EY) services are required to participate in the research fieldwork and provide information as required pertaining to the evaluation of the Demonstration Project.
- Adherence to Child Protection Policy must take place in line with legislation.
- EY services are responsible for informing parent(s)/caregiver(s) about the Demonstration Project.
- In-service therapy supports will be planned, implemented and reviewed in line with the Síolta framework and Aistear curriculum.

Universal Service Support	Targeted Service Support	Intensive Service Support
Who is involved? Service management, EY project team, EY practitioners, parent(s)/caregiver(s), children, OT, SLT	**Who is involved?** Service management, EY project team, EY practitioners, parent(s)/ caregiver(s), children, relevant external agencies, OT, SLT	**Who is involved?** Service management, EY project team, EY practitioners, parent(s)/g caregiver(s), children, relevant external agencies, OT, SLT
EY Service: • to facilitate planning meetings with relevant staff and project OT/SLT over the duration of the project • to support the implementation of whole service project targets • to facilitate CPD/ learning activities for the whole staff and/or parent(s)/caregivers(s) as agreed by the EY project team and project OT/SLT.	**EY Service:** • to facilitate collaboration between EY practitioners, parents and the project OT/ SLT to identify children who require additional supports to those already provided at universal support level • to facilitate relevant EY practitioners to work in partnership with the project OT/SLT to plan and implement agreed targeted supports • to monitor, review and document children's progress, in conjunction with the project OT/SLT • to inform and obtain consent from parent(s)/ caregiver(s) in relation to planned targeted support for identified children.	**EY Service:** • to obtain informed written consent from parent(s)/ caregiver(s) • to facilitate collaboration between EY practitioners and the project OT/SLT to identify children who require individualised support in the learning environment. This is in addition to the supports provided at the universal and targeted levels • to facilitate relevant EY practitioners to work in partnership with the project OT/SLT to plan and implement agreed individualised supports • to monitor, review and document individual children's progress, in conjunction with the project OT/SLT and parent(s)/caregiver(s).

Universal Service Support	Targeted Service Support	Intensive Service Support
Who is involved? Service management, EY project team, EY practitioners, parent(s)/caregiver(s), children, OT, SLT	**Who is involved?** Service management, EY project team, EY practitioners, parent(s)/ caregiver(s), children, relevant external agencies, OT, SLT	**Who is involved?** Service management, EY project team, EY practitioners, parent(s)/g caregiver(s), children, relevant external agencies, OT, SLT
Project Therapists: • to work with management, EY practitioners and parent(s)/caregiver(s) in reviewing current OT/ SLT universal service supports, as appropriate • to work with management, EY practitioners and parent(s)/caregiver(s) in identifying, planning and implementing OT/ SLT targets for universal support • to provide training and information to EY practitioners and/or parent(s)/caregiver(s) to support all children to participate to the best of their ability in the learning environment • to maintain appropriate records of support provided, in EY service and project office.	**Project Therapists:** • to ensure that informed written consent has been obtained from parent(s)/ caregiver(s) for targeted service support • to work in collaboration with EY practitioners and parent(s)/caregiver(s) in identifying and supporting groups of children with ongoing OT/SLT needs in the learning environment • to provide targeted support for EY practitioner-led interventions, e.g. training, guidance on specific strategies/programmes, skills coaching, etc. • to review children's progress in collaboration with EY practitioners and/or parent(s)/caregiver(s) • to maintain appropriate records of support provided, in EY service and project office.	**Project Therapists:** • to ensure that informed written consent has been obtained from parent(s)/caregiver(s) for intensive service support • to provide support and guidance on identifying children who have significant and persisting needs and require additional supports to those provided at the universal and targeted service support levels • to provide individualised OT/ SLT recommendations and resources for integration into the service and home environments, in collaboration with EY practitioners, parent(s)/ caregiver(s) and relevant external services • to provide support and guidance regarding referral to/ liaison with relevant external agencies • to maintain appropriate records of support provided, in EY service and project office.

Appendix E: Overview of the Range of Documentation Examined

Data Sources Available at Review

1. Minutes of management meetings through from project kick-off to present
2. Updated project management documentation
3. Review materials for phase 1 and phase 2
4. Appraisal of staff induction
5. Geographical clusters
6. CPD information
7. Orientation and introduction materials
8. Schools information booklet
9. Schools engagement resources; letters, PowerPoints etc.

Data Sources Gathered during Review

1. Therapists brainstorming session: field notes
2. Interviews with management team members: field notes
3. Management team brainstorming session: detailed minutes
4. Management team survey: online survey

Additional Data Sources

1. Target Tracker system (all levels): outcomes and progress tool used by therapists and management team
2. Roles documentation for therapy managers and clinical leads
3. Memorandum of understanding
4. Additional refinement of the tiered model following iterative review by management team

Appendix F: Online Questionnaire Example

Electronic questionnaire for school principals/ Early Learning and Care Centre Manager

Dear Principal/ Manager,

You are invited to take part in an electronic questionnaire, which forms part of a research project being undertaken by University College Cork (UCC) and Mary Immaculate College (MIC), under Principal Investigator Dr. Helen Lynch and Associate Principal Investigators Dr. Ciara O' Toole (UCC) and Dr. Emer Ring (MIC) in the Discipline of Occupational Therapy, Speech and Language Therapy and Education. In addition, there is a research team to support the workings of this project located in UCC and MIC.

This project has been funded by the National Council for Special Education to evaluate the effectiveness of the new In-school and Pre-school Therapy Demonstration project that is being rolled out in your school/ Early Learning and Care (ELC) Centre.

The purpose of this questionnaire is to collect demographic data on your school/ ELC centre to establish a baseline of existing practices and processes that can be used to generate benchmarks for further investigation as the Demonstration project is rolled out over the 2018-2019 school year.

You are invited to participate in this research project because you have in-depth knowledge on your school/ ELC centre that is participating in this Demonstration project. Your participation in this research study is voluntary, so you may choose not to participate.

The procedure involves completing an electronic questionnaire that will take approximately 10 to 20 minutes.

Your participation in this research study is voluntary, so you may choose not to participate. Should you choose to participate, your name, place of work, and IP address will be recorded in the electronic questionnaire so that we can link the information collected to individual settings. As this evaluation is concerned with examination of the In-Schools Therapy Demonstration project all data gathered will be available to the research team and to the staff of the NCSE for the duration of the project and may be published as part of reports or other outputs as determined by the NCSE in collaboration with this research team. All data is stored in a password protected electronic format. You will be provided with access to your data via direct request to the research team (see contact details below) for the duration of this evaluation project. Thereafter access to your data will not be possible as it will be anonymised for secure archiving.

Ethical approval for this research has been granted from the Social Research Ethics Committee, University College Cork.

If you have any questions about the research study, please contact Helen Lynch (h.lynch@ucc.ie).

To complete this questionnaire please click on the following link: ...

Note: Consent is implied by completed submission of the electronic questionnaire.

Your time in completing this questionnaire is much appreciated.

Kind regards,
Helen, Ciara and Emer
(on behalf of the research team)

1. Would you describe your school/ Early Learning and Care (ELC) centre as ...

- [ ] Montessori
- [ ] Pre-school
- [ ] Creche
- [ ] Nursery
- [ ] Primary National School
- [ ] Primary School
- [ ] Private School
- [ ] Secondary School
- [ ] Special Education Centre
- [ ] Gaelscoil
- [ ] Educate Together School

Other (please specify)

2. How many students/children does the school/ELC centre serve?

- ○ 0 - 50
- ○ 50 - 100
- ○ 100 - 500
- ○ 500+

3. How is the school/ ELC centre best described?

- ○ Boys
- ○ Girls
- ○ Mixed
- ○ Private
- ○ Government funded

4. Please indicate the nummber of educators at your site

5. Please indicate the number of learning support staff at your site

6. Please indicate the number of allied health professionals at your site

7. Do you think your school is ...
(tick all that apply)

- [ ] Located in an area of educational disadvantage
- [ ] Providing education for children from the Travelling Community
- [ ] Providing English Langauge support to children and parents where English is not their first language

8. Please indicate the number of staff members with additional training and qualifications relating to the support of children with special needs in your school/ ELC centre

9. Please indicate the level of competence and abilities posessed by the school staff in handling learners with special needs

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

10. Please indicate the number of children with declared PHYSICAL DISABILITIES (for example, Spina Bifida, Cerebral Palsy) that are enrolled in your school/ELC centre

11. Please indicate the number of children with declared INTELLECTUAL DISABILITIES (for example, Down Syndrome) that are enrolled in your school/ELC centre

12. Please indicate the number of children with declared LEARNING DIFFICULTIES (for example, dyslexia, dysgraphia) that are enrolled in your school/ELC centre

13. Has your school/ ELC centre put in place management policies to handle learners with special needs?

- ○ Yes (policies in place and in operation)
- ○ No (we are aware that this may be useful but we hav not put anything specific in place)
- ○ Not sure

14. Does your school/ELC centre have enough resources and facilities to suppiort all learners

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

15. Please indicate the resources and facilities that you have available to support the inclusion of all children with/without disabilities in your school/ELC centre

16. Has your school/ELC centre sought the support of any of the following services for a child/children at any point in the last 3 years?

- ☐ Visiting Teacher Service
- ☐ Special Education Needs Officer
- ☐ Assistive Technology Grant
- ☐ Special Transport
- ☐ Reasonable accomodation in Certificate exams scheme
- ☐ Exemption from Irish

Other (please specify)

Electronic questionnaire for therapy staff

Dear Therapist,

You are invited to take part in an electronic questionnaire, which forms part of a research project being undertaken by University College Cork (UCC) and Mary Immaculate College (MIC), under Principal Investigator Dr. Helen Lynch and Associate Principal Investigators Dr. Ciara O' Toole (UCC) and Dr. Emer Ring (MIC) in the Discipline of Occupational Therapy, Speech and Language Therapy and Education. In addition, there is a research team to support the workings of this project located in UCC and MIC.

This project has been funded by the National Council for Special Education to evaluate the effectiveness of the new In-school and Pre-school Therapy Demonstration project that you have responsibility for rolling out as employed therapy staff.

The purpose of this questionnaire is to collect data to establish a baseline of existing practices and processes that can be used to generate benchmarks for further investigation as the Demonstration project is rolled out over the 2018-2019 school year.

You are invited to participate in this research project because you have been employed as therapy staff responsible for rolling out this new Demonstration project. Your participation in this research study is voluntary, so you may choose not to participate.

The procedure involves completing an online questionnaire that will take approximately 10 to 20 minutes.

Your participation in this research study is voluntary, so you may choose not to participate. Should you choose to participate, your name, place of work, and IP address will be recorded in the electronic questionnaire so that we can link the information collected to individual settings. As this evaluation is concerned with examination of the In-Schools Therapy Demonstration project all data gathered will be available to the research team and to the staff of the NCSE for the duration of the project and may be published as part of reports or other outputs as determined by the NCSE in collaboration with this research team. All data is stored in a password protected electronic format. You will be provided with access to your data via direct request to the research team (see contact details below) for the duration of this evaluation project. Thereafter access to your data will not be possible as it will be anonymised for secure archiving.

Ethical approval for this research has been granted from the Social Research Ethics Committee, University College Cork.

If you have any questions about the research study, please contact Helen Lynch (h.lynch@ucc.ie).

To complete this questionnaire please click on the following link: ...

Note: Consent is implied by completed submission of the electronic questionnaire.

Your time in completing this questionnaire is much appreciated.

Kind regards,
Helen, Ciara and Emer
(on behalf of the research team)

1. What is your role in the In-school and Pre-school Therapy Demonstration project?

- ○ Occupational Therapist
- ○ Speech and language therapist

2. What is your grade?

- ○ Senior therapist
- ○ Basic grade therapist

3. How many years have you worked as a paediatric OT/SLT?
Please round up to the nearest full year

4. Have you previous experience of working in schools as an OT/SLT?

- ○ Yes
- ○ No

5. If you answered yes to Q. 4, how many years experience do you have working in schools as an OT/SLT?
Please round up to the nearest full year

6. If you answered yes to Q. 4, in what settings did you work?

- ☐ Early Learning and Care settings
- ☐ Primary schools
- ☐ Post-primary schools
- ☐ Special schools
- ☐ Other (please specify)

7. Under this new In-school and Pre-school therapy demonstration project, what settings do you cover? (Tick all that apply)

- ☐ Montessori
- ☐ Pre-school
- ☐ Creche
- ☐ Nursery
- ☐ Primary National school
- ☐ Primary school
- ☐ Private school
- ☐ Secondary school
- ☐ Special Education Centre
- ☐ Gaelscoil
- ☐ Educate Together School

Other (please specify)

8. Have you engaged with all of the settings that you have been allocated to?

- ○ Yes
- ○ No

9. If you answered yes to Q. 7, what has this interaction been about?

- ☐ Information session
- ☐ Working with the whole school
- ☐ Working with individual classes
- ☐ Other (please specify)
- ☐ Working with individual children
- ☐ Working with parents
- ☐ Working with therapists in external agencies

10. If you answered no to Q. 7, have there been barriers to engaging with the settings?

11. Do you believe that you can successfully implement the tiered model of service delivery in Early learning and Care settings?

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

12. Do you believe that you can successfully implement the tiered model of service delivery in primary schools?

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

13. Do you believe that you can successfully implement the tiered model of service delivery in post-primary schools?

- ○ Not at all
- ○ Very small extent
- ○ Small extent
- ○ Moderate extent
- ○ Fairly great extent
- ○ Great extent
- ○ Very great extent

14. Do you believe that you can successfully implement the tiered model of service delivery in special schools?

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

15. What are the structures and processes in place for implementing the tiered model of service delivery in Early Learning and Care settings and schools?

16. What are the key facilitators in the implementation of the tiered model?

17. What are the key barriers in the implementation of the tiered model?

18. Did you recieve training on the tiered model?

Not at all	Very small extent	Small extent	Moderate extent	Fairly great extent	Great extent	Very great extent
○	○	○	○	○	○	○

19. Who delivered the training?

- [ ] HSE OT manager
- [ ] HSE SLT manager
- [ ] NCSE OT project manager
- [ ] NCSE SLT project manager

Other (please specify)

20. What did this training consist of?

21. Do you think the tiered model is an effective way to deliver school-based therapy services?

- ○ Yes
- ○ No

22. For you, what types of therapy intervention fit under Tier 3 of the model?

23. For you, what types of therapy intervention fit under Tier 2 of the model?

24. For you, what types of therapy intervention fit under Tier 1 of the model?

25. Please rate your competence with respect to the following

	Area for learning				Highly competent
Explaining the tiered model to parents	○	○	○	○	○
Explaining the tiered model to teachers	○	○	○	○	○
Explaining the tiered model to therapist colleagues	○	○	○	○	○
Assessing a child within a classroom/ school setting	○	○	○	○	○
Integrate assessment and intervention strategies in a school setting	○	○	○	○	○
Identifying struggling students in a school setting (classroom/ outdoors)	○	○	○	○	○
Coach teachers within their classrooms with respect to identifying struggling children	○	○	○	○	○
Help teachers use curriculum-based activities to identify struggling children	○	○	○	○	○
Translate knowledge to teachers about the challenges struggling children may face at home and in the classroom	○	○	○	○	○
Translate knowledge to teachers about potential strategies that may assist with these challenges	○	○	○	○	○
Translate knowledge to parents about the challenges struggling children may face at home and in the classroom	○	○	○	○	○
Translate knowledge to parents about potential strategies that may assist with these challenges	○	○	○	○	○

26. Please rate youe level of competence with respect to the following skills

	Area for learning				Highly competent
Model skills and/or strategies for educators and relevant support staff within thier classrooms	○	○	○	○	○
Advocate for your role as a resource within the school system	○	○	○	○	○
Design and implement structured knowledge translation activities for teachers (for example, lunch `n learn)	○	○	○	○	○
Modify or adapt tasks, activities or environments to enhance successful participation of children	○	○	○	○	○
Coach teachers to be able to bridge, transfer or generalise their knowledge to support other children	○	○	○	○	○
Tailor communication style and strategies to meet the needs of children	○	○	○	○	○
Tailor communication styles and strategies to meet the needs of parents	○	○	○	○	○
Tailor communication styles and strategies to meet the needs of teachers	○	○	○	○	○
Recat to difficulties, challenges or obstacles by trialing new approaches or strategies	○	○	○	○	○

Appendix G: World Café Processes

World Café (Focus Group) for SLTs and OTs

1. What is your impression of how the tiered model was implemented in this project within each of the educational settings?

    a. From your experience, were there specific facilitators in implementing the model?'

    b. From your experience, were there specific barriers in implementing the model?'

2. How do you feel the model served the needs of children as a group, and the individual needs of the children? Do you think the tiered model as you delivered it was an appropriate approach?

3. What do you think are the main outcomes of this project when compared to current practice on everyone involved (children, families, educators, special needs/inclusion support assistants, therapists, others?)

4. Do you think that the project influenced your co-practice with educators and relevant support staff? (e.g. knowledge of the curriculum, teacher-therapist relationship, understanding of each other's role). Did it have an effect on the relationship with parents?

5. How would you change/improve how this project is implemented in the future? (for example, logistics/management, continued professional development, number of sites, types of educational settings etc.)

Appendix H: Sample Interview Transcripts

Parent Phone Interview Example of Part of a Transcript

7.4.1 ELC_C_P1 – 24-7-2019 – 10.00-10.21

(1) How did you become aware of the In-School and Early Years Therapy Support Demonstration Project being rolled out in your child's school/Early Years setting?

I became aware of the project through posters and leaflets. Maybe there was also, a consent form. Parents were invited to attend an initial evening meeting where the OT and the SLT outlined the project as involving universal, targeted and 1:1 support. There was also a drop-in-morning session with the therapists. I have three children and my youngest has a stammer. The SLT gave me some strategies to implement and also these were being implemented in the setting. These strategies were 'particularly helpful'. The SLT also gave me a referral form and I got an appointment immediately. I wonder if saying that my son had been seen by a SLT in the Demonstration Project made the process more immediate rather than going through a GP. My daughter is 10 and has autism. She is in a mainstream school and is on a waiting list for psychological and OT services for some time.

- What were your thoughts about having school-based therapy services?

  I have three children and my youngest has a stammer. 'I was surprised something so innovative was happening and readily accessible'.

- Have your thoughts changed over the year? If so can you tell me about that

  'I thought it was a great idea and my thoughts haven't changed'

(2) Were you aware of any therapy work that was done in your child's school/ Early Years setting? If so...

- What was involved?

  Universal and in small groups – *'I am not sure about 1:1 – more in general'*

- What was the aim of this service do you think?

  To improve children's development

- What did you think of it?

  'particularly helpful' – 'really consistent' – 'everybody doing the same thing'

- Did it work?

  'definitely my child's stammer was improving' Unfortunately he ended up in hospital recently and this has set him back but he will be staying in the ELC setting next year.

(3) Did you have any direct contact with the Occupational Therapist/Speech and Language Therapist assigned to your child's school/Early Years setting? If so...

- Can you tell me about that...?
  - What was the reason for the contact?

  I attended the drop-in session and we had been concerned for six months about my son's stammer. 'It was fabulous just being able to go in there and then'.

  - What happened?

  The SLT gave me a list of strategies, which were shared also with the educators and advised me to refer the child to the HSE.

  - What was the outcome?

  Child's stammer improved and we got an appointment and didn't have to go through GP.

  - What did you think about it?

  'I find it amazing. It felt like early intervention'. 'Everybody talks about early intervention. If you address these things sooner, surely it becomes more complex later and the chances of success are diminished'. 'I could see a positive benefit more quickly'.

(4) Did you have any other ideas about how school-based therapy should work best? If so...

- Can you tell me about it?

  'It was actually fantastic'. 'I don't know, maybe a small bit of follow up – nothing onerous, just saying "this is what we did" – a two-minute phone call'.

- What makes you think that?

(5) If this Demonstration Project was to be rolled out in other schools/ELC settings around Ireland, what would you recommend?

The first evening meeting was 'not massively well attended' I realise people are busy but if you missed one meeting then you may not have been aware of what is going on and 'such a fabulous resource' – Maybe having another meeting. 'I wonder if they are doing themselves a disservice by not publicising it a bit more. Maybe having a newsletter once a quarter – short and simple that you could pick up when you collect your child – quick and easy to do'.

'I really hope it is rolled out. It is incredible, innovative and proactive and actually early intervention'.

Appendix I: Sample Information Letters and Consent/ Assent Forms

Dear School Principal/Early Learning and Care setting Manager, As you are aware, we are the people responsible for evaluating the effectiveness of the new Demonstration project that is being implemented in your setting. This research is being undertaken by University College Cork (UCC) and Mary Immaculate College (MIC) under the direction of Principal Investigator Dr. Helen Lynch[84] and Associate Principal Investigators Dr. Ciara O' Toole[85] and Dr. Emer Ring[86]. In addition, there is a research team to support the workings of this project located in UCC and MIC. This project has been funded by the National Council for Special Education to evaluate the effectiveness of the new In-school and Pre-school Therapy Demonstration project that is being rolled out.

As the evaluation team with responsibility to evaluate the effectiveness of the Demonstration project being rolled out in your setting, we have selected 20 of the 150 sites as representatives to further explore the effectiveness of the Demonstration project. These 20 sites will feature as case study sites in our evaluation project. Your setting has been selected as one of these 20 sites.

Your participation in this research study is voluntary, so you may choose not to participate. Should you choose to participate, the Research Team will ask you to:

1. As principal/manager, to **participate in a phone interview**. The purpose of this phone interview is to elaborate on questions included in the electronic questionnaire (sent to you on 6th February 2019) as well as offer an opportunity to offer further information on the project. Should you choose to participate a member of the Research Team will contact you to set up a phone interview at a time that is convenient to you. The phone interview would last approximately 30 minutes. This interview will be recorded on a Dictaphone and transcribed verbatim. As this evaluation is concerned with examination of the In-Schools Therapy Demonstration project all data gathered will be available to the research team and to the staff of the NCSE for the duration of the project and may be published as part of reports or other outputs as determined by the NCSE in collaboration with this research team. All data is stored in a password protected electronic format. You will be provided with access to your data via direct request to the research team *(see contact details below)* for the duration of this evaluation project. Thereafter access to your data will not be possible as it will be anonymised for secure archiving.

84 Dr. Helen Lynch works in the Department of Occupational Science and Occupational Therapy, UCC.

85 Dr. Ciara O Toole works in the Department of Speech and Hearing Sciences, UCC.

86 Dr Emer Ring is Dean of Education, MIC.

2. **Select two representatives from your setting to participate in a focus group** with members of the Research Team as well as staff from other settings selected. The purpose of this focus group is to elaborate on questions included in the electronic questionnaire sent to educators and relevant support staff in your setting, as well as offer an opportunity to offer further information on the project. Once you identify representatives, members of the Research Team will provide them with information about what their participation would entail so that they could make an informed choice as to whether or not they would like to participate. Should your staff member choose to participate, the focus group would take approximately 60 minutes to complete and will be hosted in a hotel in Dublin.

Ethical approval for this research has been granted from the Social Research Ethics Committee, University College Cork.

I hope you will look favourably on this request. Should you require further information on any aspect of the research please do not hesitate to contact me at the details given below:

Dr. Helen Lynch
Tel: (021) 490 1535
E-mail: h.lynch@ucc.ie

Kind regards, Helen, Ciara and Emer
(On behalf of the research team)

Consent Form for Principals/Managers

Name:

Role (please tick the relevant box):

Principal of Primary School	
Principal of Post-Primary School	
Principal of Special School	
Manager of Early Learning and Care Setting	
Other (please state your role)	

This is to confirm that (please tick the box):

I have read the attached information letter which explains the research study ☐

I understand that the letter is asking me to consent to my participation in an interview ☐

I understand that all the information gathered will be kept strictly confidential, which means that my name will not be included in any written reports, publications or presentations. ☐

I understand that the research team cannot guarantee my anonymity due to the small sample size. ☐

I understand that in addition to my participation being voluntary, I am is free to stop participating in the research at any time during or up to 2-weeks post interview, without reason. ☐

I understand that the interview will be recorded on a dictaphone and offer my consent for quotes to be used in the project outputs. ☐

I understand that the research will be published by the National Council for Special Education and that the researchers might publish the information in professional journals. ☐

I understand that the researchers might present the information at conferences and seminars. ☐

I freely consent for my participation in the study. No-one has put pressure on me.

Signature(s):	Date:

Contact for further information

If you would like to find out more about the study, you can contact:
Dr. Helen Lynch Tel: (021) 490 1535 E-mail: h.lynch@ucc.ie

Research Project: Evaluating the Effectiveness of the In-School and Early Years Therapy Support Demonstration Project

Dear Parent/Guardian,

A team of researchers in University College Cork and Mary Immaculate College Limerick is conducting a study to evaluate the effectiveness of the In-school and Early Years Therapy Support Demonstration Project currently being rolled out in your setting. This research has been commissioned by the National Council for Special Education and is led by Dr. Helen Lynch (UCC), Dr. Ciara O' Toole (UCC) and Dr. Emer Ring (MIC). This study aims to evaluate the effectiveness of the In-school and Pre-school Therapy Support Demonstration Project currently being rolled out in your child's school/Early Years setting and to publish a report detailing the findings of the research.

The research will comprise a one-day visit to the school/Early Years setting by two/three researchers from University College Cork and Mary Immaculate College. During the visit to your child's school/Early Years setting, a two/three-person research team will engage in a period of classroom discussion of up to one hour in a selected class where students have engaged with the Occupational Therapist (OT) and/or Speech and Language Therapist (SLT) assigned to your child's school/Early Years setting under the In-school and Early Years Therapy Support Demonstration Project. The lesson where the discussion takes place will be agreed with the class teacher/room leader prior to the visit. Discussions with children will use a 'draw and write/talk technique' – children will be asked to discuss/write about their school/ELC setting-experience and they will be asked to draw a picture of school/ELC setting. It will be stressed that they do not have to answer questions or draw a picture and may leave the group at any time. It will be necessary to audio-record the student conversations to ensure that all of the information is retained. All data will be closely examined to identify the themes and issues related to the issue being researched.

During the visit to your child's school/Early Years setting, the researchers will conduct interviews with special needs assistants. This researcher will also conduct an individual interview with the principal/manager.

The school/Early Learning and Care setting, which your child attends has been invited and has agreed to participate in the research project and your co-operation would be greatly appreciated. We now invite you to participate in a short telephone interview. Interviews will begin in the week beginning (dd/mm/yyyy) on a day and time that suits you. Again, it will be necessary to audio-record the interview with you to ensure that all of the information is retained. Your participation in the research will be voluntary, you will be free to refuse to answer any question and you may choose to withdraw from the project at any time during or up to 2-weeks post data collection without consequence. Withdrawal after this time will not be possible, as the data will be anonymised for secure archiving. Electronic and written information will be kept strictly confidential, subject to the limitations of the law, and will be available only to the research-team. Excerpts from the data collected during the research process may be used in

the final report, but under no circumstances will your name or any identifying characteristics be included. Data collected for the research will be stored securely on a password-protected computer and in locked cabinets. All data will be destroyed after a period of ten-years. Data may be used in an anonymous form in any publications that arise from this research.

1. If you are interested in participating in a parent/guardian-telephone interview as part of this research, we would be grateful if you would sign the attached consent form and indicate a suitable day and time to receive the call.
2. If you are interested in having your child participate in the student conversation, we would be grateful if you would sign the attached form providing consent for your child to participate in the research.

We would be grateful if you would return these consent forms to the school by (dd/mm/yyyy) in the envelope provided. Following receipt of these forms, Emer Ring/Lisha O' Sullivan/Therese Brophy, all of Mary Immaculate College will be in touch with you at your preferred date and time to conduct the interview with yourself. The interview with your child will take place on the day the researchers' visit to the school/Early Years setting.

In the meantime, please do not hesitate to contact us if you have any queries:

- Dr. Emer Ring (Emer.Ring@mic.ul.ie / 061 204571)
- Dr. Lisha O' Sullivan (Lisha.OSullivan@mic.ul.ie)
- Dr. Therese Brophy (Therese.Brophy@mic.ul.ie)

Yours Sincerely,

Dr. Emer Ring, Dr. Lisha O' Sullivan & Dr. Therese Brophy
(On behalf of the research team)

Parent/Guardian Consent Form

Research Project: Evaluating the Effectiveness of the In-School and Early Years Therapy Support Demonstration Project

Name:	
School/Early Years setting:	

I _____ am willing to participate in the research study entitled 'Evaluating the Effectiveness of the In-school and Early Years Therapy Support Demonstration Project' being conducted by University College Cork and Mary Immaculate College, Limerick on behalf of the National Council for Special Education. I have been given sufficient information about the project and I understand the nature of the research project. I am satisfied that the data can be used in anonymous form in any publications that arise from this project.

Suitable day:	
Suitable time:	
Phone:	

Signed:
Date:

Parent/Guardian Consent Form for Child to Participate

Research Project: Evaluating the Effectiveness of the In-School and Early Years Therapy Support Demonstration Project

Name of parent/guardian:	
Child's Name:	
Child's age:	
Name of school/Early Years setting:	

I _____ give permission to have my child _____ participate in the research study entitled 'Evaluating the Effectiveness of the In-school and Early Years Therapy Support Demonstration Project' being conducted by University College Cork and Mary Immaculate College, Limerick on behalf of the National Council for Special Education. I have been given sufficient information about the project and I understand the nature of the research project. I am satisfied that the data can be used in anonymous form in any publications that arise from this project.

Signed:
Date:

Child/Student Assent Form

Name:	
School/Early Years setting:	

Are you happy to talk to me about school today?





Are you happy for me to write down what you tell me in my book?





Are you happy to draw a picture about school?





Are you happy for me to put your picture in my book?





Are you happy for me to record what you are saying?





Signed:

Date:

Appendix J: Project Plan for Demonstration Project

Demonstration Project on In-School and Early Years Therapy Support

Project Plan

2018-2019

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

Aims of Demonstration Project

Schools:

- To develop and evaluate a multi-tiered continuum of support therapy model which aims to build capacity and inclusion in educational settings.
- To support the learning, engagement and participation of all students by facilitating access to all aspects of the curriculum for schools.
- To explore and develop effective models of collaborative partnership between in-school project therapists, school staff, the Department of Education and Skills and the Department of Health and HSE services with a view to achieving better educational outcomes for students and their families.
- To explore and develop models of effective cross-sectorial collaboration and pathways to ensure clarity of roles and optimal use of resources between in-school therapists and therapists in statutory and non- statutory organisations.

Schools have been selected for participation in the project by the Educational Research Centre according to defined sampling criteria which gives a representative sample of schools. Schools have been invited to participate in the project on a voluntary basis.

Early Years Settings:

- To develop and evaluate a multi-tiered continuum of support therapy model which aims to build capacity and inclusion in educational settings.
- To support the learning, engagement and participation of all children by facilitating access to all aspects of the curriculum for early years settings.
- To explore and develop effective models of collaborative partnership between in-setting project therapists, early years staff, the Department of Children and Youth Affairs, the Department of Education and Skills and the Department of Health and HSE services with a view to achieving better educational outcomes for children and their families.
- To explore and develop models of effective cross-sectorial collaboration and pathways to ensure clarity of roles and optimal use of resources between in-setting therapists and therapists in statutory and non- statutory organisations.

Early years settings have been randomly selected for participation in the project by the Department of Children and Youth Affairs using a defined sampling criteria. Settings have been invited to part in the project on a voluntary basis.

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

Project Timelines

The Demonstration Project on In-school and Early Years Therapy Support is divided into four stages: -

Stages	Dates	Actions
Stage 1	7th August – 5th December, 2018	Project set up and implementation
	6th December – 12th December, 2018	Internal project evaluation of Stage 1 actions
	13th December – 20th December, 2018	Sign off on Stage 2 actions
Stage 2	2nd January – 12th April, 2019	Implementation of Stage 2 actions
	15th April – 19th April, 2019	Internal project evaluation of Stage 2 actions
	23rd April – 26th April, 2019	Sign off on Stage 3 actions
Stage 3	29th April – 31st July, 2019	Implementation of Stage 3 actions: ▪ Actions related to direct support by therapists to 150 sites will end on the following dates - - Post- primary – 31st May - Primary – 28th June - Early years – 31st July
	22nd July – 26th July, 2019	Internal project evaluation of Stage 3 actions
	29th July – 31st July, 2019	Sign off on Stage 4 actions
Stage 4	1st August – 30th August, 2019	Implementation of Stage 4 actions
	30st August, 2019	Project closure
	September 2019	Formal report submitted by evaluators

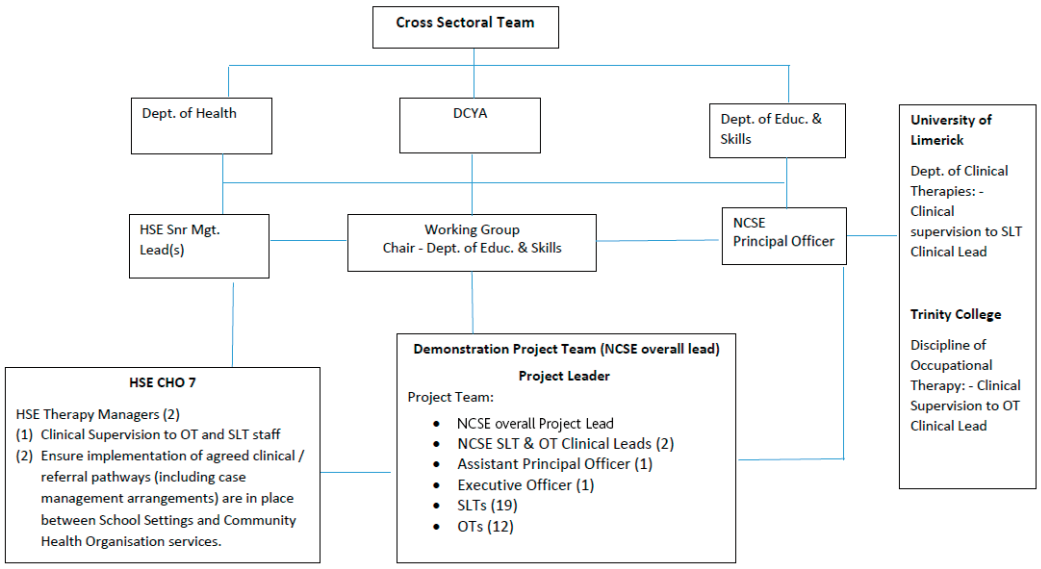
Formal evaluation of Demonstration Project:

Dates for interim reporting by evaluators not yet available.

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

Demonstration Project on In-School and Early Years Therapy Support



Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

Project Schedule Stage 1 - (1ST August – 7th December 2018)

	Actions	Key Elements	Completion Status *Review 10th – 14th Dec.*	Responsibility
1	**Develop MoU between Department of Education and Skills, NCSE, HSE and DCYA**	▪ Develop MoU ▪ Sign MoU		Working Group
2	**Draw up a budget for project**	▪ Develop a budget template ▪ Confirm Budget for duration of the Project ▪ Put in place agreement with DES/DCYA/HSE re breakdown of expenditure ▪ Identify budget expenditure for 2018 ▪ Monitor expenditure and ensure all is in line with NCSE financial procedures ▪ Prepare budget for 2019 ▪		Project Lead Project AP
3	**Develop Project Frameworks for SLT and OT therapy support**	▪ Develop SLT and OT Framework for schools ▪ Develop SLT and OT Framework for EYs ▪		Working Group
4	**Establish two project hubs**	▪ Establish functioning Dublin and Kildare hubs ▪ Supply Equipment to therapist ▪ Establish an office management system (ordering, recording deliveries etc.) ▪ Adherence to health and safety regulations ▪ Maintenance of hubs ▪		Project Lead Project AP
5	**Recruit:** ▪ **19 SLTs** ▪ **12 OTs** ▪ **1 EO**	▪ Recruit 19 project SLTs ▪ Recruit 12 project OTs ▪ Appoint project EO ▪		HSE

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

6	**Organise an Induction Programme for Therapists**	▪ Multi-tiered continuum of support model (NCSE) ▪ SLT/OT Frameworks (NCSE) ▪ Aistear Framework and Curriculum (DCYA) ▪ Early Years systems (DCYA) ▪ Primary Curriculum/School Structure (NCSE) ▪ Post Primary Curriculum/School Structure (NCSE) ▪ Wellbeing Guidelines (NCSE) ▪ Literacy and Numeracy Strategy (NCSE) ▪ Special School Structure and Curriculum (NCSE) ▪ L1LP (JCT) ▪ L2LP (JCT) ▪ NEPS Support in Schools (NEPS) ▪ Co-teaching (NCSE) ▪ Digital Framework (PDST) ▪ Work of VTs (NCSE) ▪ Work of SENOs (NCSE) ▪ Learning from Looking at Our School (DES Inspectorate) ▪ Learning from EY Inspections (DES Inspectorate) ▪		Project Management Team
7	**Adhere to Child Protection regulations**	▪ Provide CPD on Child Protection to Therapists (HSE) ▪ Provide evidence to school/early years management that therapists have been Garda vetted ▪ Provide ID badges to therapists ▪		Project Management Team
8	**Establish Project Clinical Governance/Peer Support/Meeting Systems**	▪ Establish a Clinical Supervision System ▪ Establish a peer support/mentoring system ▪ Establish an internal meeting system for project ▪ Establish an internal project communication system ▪		Project Management Team
9	**Allocate therapists to schools/Early Years Settings**	▪ Assign therapists to schools and early years settings ▪ Establish clusters of school and early years clusters ▪		Project Management Team
10	**Establish ongoing relationships with CHO7 roles**	▪ HSE and HSE funded services ▪ VTs ▪ SENOs ▪ Advisors		Project Management Team

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

		▪ Psychologists ▪ KARE ▪ Menni ▪		
11	**Develop and implement a multi-tiered continuum of support model for schools/early years –** ▪ **Information** ▪ **Preparation** ▪ **Planning and resourcing** ▪ **Implementation and operationalising** ▪ **Incorporation into school/EYs systems and practice**	▪ Hold information sessions for principals/managers and second staff member ▪ Establish School/Early Years Project Teams and identify Project Lead in each school/EY ▪ Prepare presentations for internal staff information sessions in school/early years ▪ Identify and organise Primary external CPD and follow up support ▪ Identify and organise PP external CPD and follow up support ▪ Identify and organise EY external CPD and follow up support ▪ Identify current school/EY work that connects with Tier 1, 2, 3 ▪ Identify targets at Tier 1 for schools/EYs ▪ Identify targets at Tier 2 for schools/EYs ▪ Identify barriers to Tier 1 and Tier 2 work commencing in schools/EYs ▪ Identify Tier 3 support required in schools/EYs for Stage 2 ▪ Begin work at Tier 1 ▪ Begin support to children/students at Tier 2 ▪ Develop an implementation and operational plan in each school/EY ▪	Complete interim review by Friday 23rd November	Project Management Team
12	**Develop project Tier 2 and Tier 3 Parent/Guardian Consent forms**	▪ Develop Tier 2 school/EYs consent form – duty of care with school/EY ▪ Develop Tier 3 school/EYs consent form – duty of care wit SLTs/OTs ▪ Test against GDPR ▪		Project Management Team

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

13	**Establish a parent/guardian communication system**	▪ Develop parent/guardian mainstream school information letter ▪ Develop parent/guardian special school information letter ▪ Develop parent/guardian EYs information letter ▪ Translate communication into core languages ▪ Work with schools/early years to establish a parent/guardian project information system ▪		Project Management Team
14	**Establish project data gathering and recording systems**	▪ Establish recording systems for: - therapists' absences/leave - clinical notes - contact/visits to schools/EYs - tier 1, 2, 3 school/EY support - target setting, delivery and completion in schools/EYs - filing system in schools/EYs - filing system in hubs - progress notes - observation record forms - surveys - checklists - audits -		Project Management Team
15	**Review 2018 HSE Therapy Manager and Clinical Lead role definitions**	▪ Review role definition of HSE Therapy Manager for project ▪ Review role definition of Clinical Lead for project ▪		Project Management Team
16	**Define the role of an in-school/in-setting SLT and OT for the Working Group**	▪ Define the specifications and role definition of an in-school and in-setting SLT and OT ▪		Project Management Team
17	**Adhere to data protection regulations**	▪ CPD on data protection for therapists (HSE) ▪ Emails to and from schools/EYs ▪ Tier 2 and 3 parent/guardian consent forms ▪ Project recording forms ▪		Project Management Team

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

18	**Develop Tier 1, 2, 3 evidence informed resources**	▪ Identify relevant evidence informed resources for each tier of the SLT and OT frameworks ▪ Identify core evidence informed SLT resources for schools/early years ▪ Identify core evidence informed OT resources for schools/early years ▪ Identify areas not in SLT framework but identified by schools/EYs ▪ Identify areas not in OT framework but identified by schools/EYs ▪		Project Management Team
19	**Develop relevant protocols**	▪ NEPS/Project protocols ▪ DDLETB/Project protocols ▪ NCSE/Project protocols ▪ HSE (CHO7)/Project protocols ▪ KARE/Project protocols ▪ Menni/Project protocols ▪		Project Management Team
20	**Develop relevant Standard Operating Procedures (SOPS)**	▪ Communication with schools/EYs (returning of emails/phone calls etc.) ▪ Communication/meetings with parents/guardians ▪ Communication/meetings with professionals supporting students ▪ Students over 18? ▪ Data collection and storage/recording/report writing ▪ Communication/meetings with other NCSE support personnel ▪		Project Management Team
21	**Develop Pathways between project and HSE**	▪ Establish Project/HSE group to develop pathways ▪ Identify the responsibilities of project therapists and therapists from HSE/HSE funded services ▪ Map CPD provided to schools/EYs by HSE/HSE funded services ▪ Determine referral pathways with HSE/HSE funded services ▪		Project Management Team

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

22	**Brand project/publish information booklet/leaflet on project**	▪ Develop project branding in line with Government logo ▪ Develop an information booklet ▪ Develop an information leaflet ▪ Develop an easily accessible Frameworks document for teachers/EY practioners ▪ Develop a FAQ document ▪		Working Group
23	**Organise Parent/Guardian workshops**	▪ Organise parent workshops on core aspects of SLT and OT frameworks ▪		Project Management Team
24	**Establish Project Focus Groups**	▪ Establish and organise Project Focus Groups for: - - Principals and EY Managers - Project Leads in school/EYs - Special Education Teachers - Parents/guardians - Students -		
25	**Evaluation of Project**	▪ Issue tender ▪ Identify successful bidder following tender process ▪ Set out overview of project phases, milestones and timelines ▪		NCSE Research section Formal evaluators
26	**Known Exclusions**	▪ Transfer of Tier 2 and Tier 3 students from HSE and HSE funded services to project therapists ▪ Project SLT and OT services operating outside their remit ▪ Policy development in schools/EYs ▪		Project Management Team
27	**Risks**	▪ Poor project planning and oversight ▪ Insufficient engagement by schools/EYs ▪ Insufficient clinical governance ▪ Lack of role clarity ▪ Stakeholder/parent/school/early years expectations ▪ Non adherence to evidence informed practice ▪ Non adherence to Child Protection regulations ▪ Non adherence to data control regulations/GDPR		Project Management Team

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

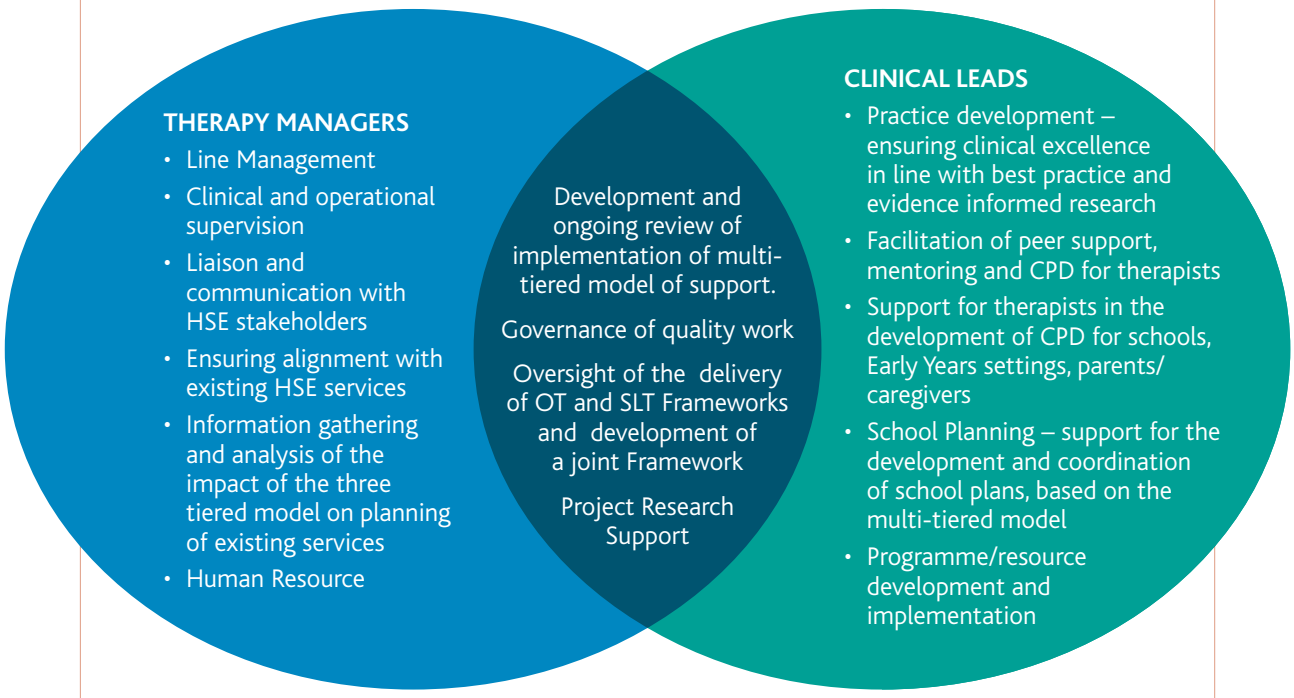
		▪ Non adherence to duty of care towards children/student(s) ▪		
28	**Stakeholders Engagement Strategy and Communication Plan**	▪ Develop a project/stakeholder/parent/school/early years communication plan ▪ Develop a project /CHO7 HSE and HSE funded services communication plan ▪		Working Group/Project Manageme

Tionscadal Léirithe um Theiripe ar Scoil agus Tacaíocht na Luathbhlianta
Demonstration Project on In-school and Early Years Therapy Support

Rialtas na hÉireann
Government of Ireland

Appendix 1

Roles and Responsibilities of Therapy Managers and Clinical Leads 2018



Project Schedule Stage 2 (1st January – 26th April, 2019)

	Action Areas	Key Elements	Completion Status	Responsibility
1	MOU between Department of Education and Skills, NCSE, HSE and DCYA	• Sign MOU	February 2019	Working Group
2	Budget for 2019	• Manage and monitor financial expenditure on the project and ensure compliance with all financial and governance regulations • Provide pay and non-pay funding to HSE on a quarterly basis as stated in the MOU • Liaise with DCYA as regards their portion of overall funding (16%) as agreed and stated in the MOU • Provide reports to DES and Working Group	Ongoing	Project AP Project Lead Oversight – NCSE
3	Project Clinical Governance	• Continue the review of Project Management Team members on project • Continue clinical supervision • Continue and further develop the practice development, peer support and mentoring structure	Ongoing	Project Management Team
4	Recruitment of Therapists	• Initial recruitment of nineteen SLTs and twelve OTs completed (February '19) • Continue cover system introduced for therapists • Ongoing recruitment of therapists – two therapists leaving due to work opportunities	Completed Ongoing	– HSE – HSE Therapy Managers – Project Lead
5	Induction programme for therapists appointed during Stage 2	• Continue induction programme for newly appointed therapists, including job shadowing system	Stage 2 timeframe	Project Management Team

	Action Areas	Key Elements	Completion Status	Responsibility
6	Continuation of CPD Programme for Therapists	Stage 2 CPD: • Co-teaching (PDST and NCSE) • Differentiation (NCSE) • Digital Framework (PDST) • Work of VTs (NCSE) • Work of SENOs (NCSE) • Role of SNA (NCSE) • Looking at Our School (DES Inspectorate) • EY Inspections (DES Inspectorate) • DCYA – ongoing EY CPD/support • Training in evidence-based programmes – under examination • Personal Development Planning (PDP) process	Stage 2 timeframe	Project Management Team Therapy Managers
7	SLT/OT Frameworks	• Continued implementation of SLT/OT Frameworks • Analyses of SLT/OT Framework content and targets set in Stage 1 and 2 • Identification of SLT/OT areas not included in current frameworks	Ongoing	Project Management Team
8a	Multi-tiered continuum of support model for schools and early years settings	• Continue to establish school/early years project teams and identify project lead in each school/EY • Continue to provide follow up support to primary teachers following external ELKLAN CPD in order to build capacity and guide teacher practice • Continue to provide follow up support to post-primary teachers following external CPD on Speech, Language and Communication Needs (SLCN) in order to build capacity and guide teacher practice • Continue to provide follow up support to EY practitioners following external CPD on Motor Skills/ Self Care/Self-regulation/Sensory Processing in order to build capacity and guide practitioner practice	Ongoing	Project Management Team

	Action Areas	Key Elements	Completion Status	Responsibility
8b	Multi-tiered continuum of support model for schools and early years settings	• Organise external CPD and follow up support for EY practitioners in Hanen 'Teacher Talk' • Organise ABC Little Voices 'Bringing Stories to Life' programme in some settings • Continue Tier 1 support already begun in schools and settings • Continue Tier 2 support already begun in some schools/settings and start Tier 2 and Tier 3 work in all schools and settings • Continue the implementation plan in each school/EY • Test the consent forms developed for Tier 2 (b) and Tier 3 support	Ongoing	Project Management Team
9	Child Protection regulations	• Provide CPD on Child Protection to newly appointed Therapists (HSE) • Examine the Child Safeguarding Statement in consultation with DES, HSE, DCYA.	February/ March 2019	Project Management Team
10	Relationship building and protocol development with HSE (CHO7) and Psychological Services	• HSE and HSE funded services • Kildare/West Wicklow Network Disability Teams • NEPS • DDLETB Psychological Services • Menni • Test the Demonstration Project/NEPS Interim Process and Procedures plan	Ongoing	Project Management Team
11	Project data gathering and recording systems which adhere to data protection legislation and professional practice	• Continually review and update recording systems for: ▪ clinical notes ▪ target setting, delivery and completion ▪ filing system in schools/EYs ▪ filing system in hubs ▪ observation record forms ▪ surveys ▪ checklists ▪ audits	March 2019	Project Management Team

	Action Areas	Key Elements	Completion Status	Responsibility
12	Learnings from Stage 1 on establishment of an in-school/setting therapy support service	• Organise for review input from principals/managers; teachers/ practitioners; therapists on the establishment stage of the project • Identify what preparatory work would be required with schools/early years settings prior to an extension of the project	April 2019	Project Management Team
13	Continue to define the role of an in-school/in-setting SLT and OT for the Working Group	• Define draft specifications and role definition of an in-school and in-setting SLT and OT therapist for the working group based on the work of the therapists in schools and early years in 2018-2019.	Ongoing	Project Management Team
14	Parent/guardian communication system	• Work with schools/early years settings to establish a parent/ guardian project information system • Organise parent workshops on core aspects of SLT and OT frameworks	April 2019	Project Management Team
15	Tier 1, 2, 3 evidence informed resources/ programmes	• Identify relevant evidence informed SLT/OT resources/programmes for each tier of the SLT and OT framework • Organise training for therapists, where required	Ongoing	Project Management Team
16	Standard Operating Procedures (SOPS)	Complete SOPs on the following: • **Data collection and storage** • Guidelines on recording, report writing, writing clinical notes • Electronic communication with schools • Communication/meetings with other NCSE **support personnel** • **Communication/meetings with parents/guardians** • **Communication/meetings with professionals supporting students** • Students over 18	April 2019	Project Management Team

	Action Areas	Key Elements	Completion Status	Responsibility
17	Pathways between project and HSE	• Continue work on the development of a referral pathways process between project therapists and HSE/ HSE funded services • Identify the responsibilities of project therapists and therapists from HSE/ HSE funded services in the pathways process	May 2019	Project Management Team
18	Brand project/ publish information booklet/leaflet on project	Finalise the following publications: • Information booklet • Information leaflet • Easily accessible Frameworks document for teachers/EY practitioners • FAQ document	March 2019	Project ▪ Manager
19	Project Focus Groups	• Establish and organise Project Focus Groups for: ▪ Principals and EY Managers ▪ Project Leads in school/EYs ▪ Special Education Teachers ▪ Parents/guardians ▪ Students	March 2019	Project Management Team
20	Evaluation of Project	• Produce interim project reports (researchers) • Provide information to researchers • Arrange office accommodation for research team, meet with team as necessary and provide access to all relevant information and project therapists.	Reports due in February, April, May, July, September, 2019	▪ NCSE Research section ▪ Researchers
21	Administrative and Hub Support	• Provision of administration support to project • Maintenance of database for 150 sites, e filing system • Support for external CPD • Organisation and provision of resources e.g. stationary and purchase of SLT/OT resources • Adherence to health and safety regulations • Maintenance of hubs • Provide office accommodation to researchers to carry out research	Ongoing	Project AP Project EO

	Action Areas	Key Elements	Completion Status	Responsibility
22	Exclusions	• Transfer of Tier 2 and Tier 3 students from HSE and HSE funded services to project therapists • Project SLT and OT services operating outside their remit • Policy development in schools/EYs	For duration of project	Project Management Team
23	Risks	• Poor project planning and oversight • Insufficient engagement by schools/ EYs • Insufficient clinical governance • Lack of role clarity • Stakeholder/parent/school/early years expectations • Non-adherence to evidence informed practice • Non-adherence to Child Protection regulations • Non-adherence to data control regulations/GDPR • Non-adherence to duty of care towards children/student(s)	For duration of project	Project Management Team
24	Stakeholders Engagement Strategy and Communication Plan	• Develop a communication plan for stakeholders • Develop a project/CHO7 HSE and HSE funded services communication plan	April 2019	Working Group Project Management

An Chomhairle Náisiúnta um Oideachas Speisialta
National Council for Special Education