PROFESSIONAL PRACTICE REPORTS

By

Fiona Eloïse Cane

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CHAPTER ONE

INTRODUCTION TO VOLUME TWO

INTRODUCTION TO VOLUME TWO

1.1 Overview

This thesis forms the written requirement for the Doctorate in Applied Educational and Child Psychology at the University of Birmingham, and is comprised of two discrete volumes. Volume One constitutes an original research study, entitled: "Late(r) diagnosis of ASC: Using parent narratives to understand the contextual factors associated with later diagnosis and its impact on children and families". Volume Two is comprised of four Professional Practice Reports ('PPRs' hereafter), structured in four discrete chapters, relating to educational psychology practice. This introductory chapter provides a background to this professional practice and research, by describing the Local Authority context in which it was undertaken, and provides an overview of the four PPRs.

1.2 Background and context

These PPRs were written during my second and third years of Educational Psychology ('EP' hereafter) training, between 2013 and 2015. During this time, I held a bursary position as a Trainee EP within a West Midlands Local Authority Educational Psychology Service ('EPS' hereafter).

In my second year, the majority of the placement (approximately two days per week) was spent as a school-based Trainee Educational Psychologist at a special school for pupils with Autism Spectrum Conditions ('ASC' hereafter), which caters for up to 90 pupils aged 5-19. I was attracted to this specialist position, due to my background as a specialist teacher for autism. In further developing my professional interest in ASC, I also had the opportunity to shadow my placement supervisor in the role of Specialist Senior EP for ASC. Towards the end of my second year, the EPS underwent significant

organisational change, shifting from a needs-led service to a partially-traded service, and recruiting a new Head of Service (Principal Educational Psychologist). This radically altered how schools negotiated EP involvement, as they were then required to purchase 'packages' of EP hours. Due to financial constraints, the special school in which I was based contracted the EPS for fewer hours. As a result, I joined multi-agency local area team within the Local Authority during my third year, and worked within multiple mainstream primary schools, one secondary school and I continued to work with the special school as a visiting EP.

1.3 PPR1: Understanding sensory processing and autism in the classroom

This PPR comprises a critical literature review relating to sensory processing differences in children with ASC. It addresses three research questions:

(i) *Are sensory symptoms an essential diagnostic characteristic of ASC?*

Prevalence rates of sensory symptoms in the ASC population are high (ranging from 66%-95%), but are not present in *all* children and young people ('CYP' hereafter). Sensory symptoms are not considered to be an essential diagnostic criteria of autism, although research suggests trends of similar qualitative differences in the ASC population (including a preference for concrete over abstract stimuli, difficulties with auditory filtering/hypersensitivity, visual sensory-seeking, and tactile and taste/smell sensitivities).

(ii) *What is sensory processing and how does it affect learning?*

The construct of 'sensory processing' is poorly defined, but relates to the processing of environmental stimuli across seven modalities: vision, hearing, olfaction, gustation, and

tactile, vestibular and proprioceptive systems. The literature suggests that classroom learning may be significantly affected by sensory processing differences.

(iii) *How are the sensory needs of learners with ASC addressed in educational contexts?*

The literature suggests two main approaches: Sensory Integration Therapy for which there is a lack of consistent evidence for CYP with ASC; and holistic approaches to adapting pedagogical style, curriculum delivery and the classroom environment, for which there is currently very little existing research.

1.4 PPR2: Whose problem? Everyone's solution. A case study of a systemic, solution-focused approach to therapeutic intervention in a secondary school

This Professional Practice Report describes and reflects upon a case arising from a school planning meeting with a West Midlands secondary school. The school SENCO (Special Educational Needs Coordinator) identified a 12-year-old boy presenting with externalising behavioural difficulties, and requested therapeutic support. I supported the student with a Solution-Focused Brief Therapeutic (SFBT) Intervention, as well as a solution-focused consultation with school staff working with him. In this PPR, I outline the theoretical and empirical basis for SFBT and describe how I applied its principles and techniques. I critically reflect upon the issues for EPs in conducting therapeutic work, including: evidence-based practice (and practice-based evidence), assessment and formulation, ethical principles, intervention fidelity, assessment of outcomes and EP impact. I highlight the importance of working systemically with staff members to recognise and reward positive change and conclude that successful application of individual SFBT relies on a systemic approach.

1.5 PPR3 & PPR4: Promoting school staff well-being using the ten-element map: an action research project using the RADIO model (Part 1 and 2, respectively)

During my time based at the special school (see Chapter 1), the Headteacher and Deputy identified an organisational need to improve staff well-being and invited me to initiate a project with this aim. I applied the RADIO model (Research and Development in Organisations, Timmins et al, 2003) to structure the project as an action research venture. The project is reported across two PPRs: PPR3 and PPR4. Firstly, PPR3 describes and reflects upon the initial 'clarifying concerns' phase and the 'data gathering phase'. I also briefly review the literature relating to staff well-being in school and provide critical discussion of my application of MacDonald and O'Hara's (1998) ten-element map, concluding that it has contemporary relevance as a salutogenic model of mental health. In PPR4, I reflect upon the processes during the 'organisational change mode', which involves action planning, implementation and evaluation. I explore the possible reasons for the negative evaluation data and highlight the importance of providing formative feedback in order to continue the action research cycle (diagnosis, planning, action and evaluation; Freedman, 2006). Across both papers, I offer a critical appraisal of the RADIO model with suggestions for it to be updated.

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CHAPTER TWO

PROFESSIONAL PRACTICE REPORT ONE

UNDERSTANDING SENSORY PROCESSING AND AUTISM IN THE CLASSROOM

PPR1 CONTENTS

Abstract

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i. Autistic Spectrum Condition

ii. Sensory Processing Differences

PPR1: UNDERSTANDING SENSORY PROCESSING AND AUTISM IN THE CLASSROOM

Abstract

Existing research indicates high prevalence rates of sensory processing differences in children with Autistic Spectrum Conditions ('ASC' hereafter; see Appendix 1). In this critical literature review, I evaluate research describing the patterns and prevalence of sensory symptoms in the ASC population, in order to inform an understanding of their conceptual and diagnostic status. I explore definitions and theoretical explanations of sensory processing and offer a critical appraisal of assessment and measurement tools. I present existing research describing the impact of sensory experiences on learning for children with ASC, and discuss ways in which this can be addressed. Critical discussion of these issues, led me to consider the implications for parents and professionals in applying these theoretical and empirical insights to practice (Hart, 1998). I conclude with key recommendations for updating good practice guidance and discuss the arising implications for research.

1. Introduction: Rationale and Research Questions

The rationale for this paper arose from two different directions: firstly, a lack of conceptual clarity (Jesson et al, 2011) in the long-lasting diagnostic debate about sensory processing and ASC, and secondly, dissatisfaction with the apparently 'superficial' current good practice guidance. I will firstly discuss the lack of conceptual and diagnostic clarity relating to sensory processing and ASC. A growing body of research, which will be discussed, demonstrates consistent empirical findings of higher reported rates of sensory processing differences in the ASC population. I will discuss the status of current diagnostic criteria, as well as synthesising empirical research describing the patterns and

prevalence of sensory processing differences in ASC, in order to address the first research question: Are sensory symptoms an essential diagnostic characteristic of ASC?

Secondly, an examination of current good practice guidance reveals a gap between research knowledge about sensory processing in people with ASC and the recommendations for best practice. Although sensory processing issues can occur in children without ASC, due to the high prevalence rates discussed, this paper will focus specifically on sensory symptoms in children with ASC. Current good practice documents tend to make only brief reference to the sensory needs of learners with ASC, merely acknowledging their common prevalence in this population (DCSF, 2009), or describing "hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment" as a behavioural characteristic of autism, which may impact upon classroom learning (Charman et al, 2011, p. 10). Guidance often reduces the complexities of sensory processing to over- or under- sensitivity (Charman et al, 2011; AET, 2011; NICE, 2011; DCSF, 2009). This information is also poorly communicated to practitioners: the Autism Education Trust's ('AET' hereafter) guide for teachers merely includes a footnote outlining that "children on the autism spectrum may experience some form of sensory sensitivity" (AET, 2011, p. 2). The examples provided tend to focus heavily on visual and auditory processing, and recommendations appear to be either too vague: for example that practitioners should "make reasonable adjustments within school and classrooms to reduce sensory issues" (DCSF, 2009, p. 12); or too specific: for example that practitioners should consider the "lighting, noise levels and the colour of walls and furnishings" (NICE, 2013, p8). This calls for a synthesis of existing literature to provide a deeper insight into the complexities of sensory and perceptual experiences of individuals with ASC, and to address the apparent gap between research knowledge and good practice guidance. This predicates two further research questions (i) What is sensory processing and how does it affect learning? and (ii) How are the sensory needs of learners with ASC addressed in educational contexts?

2. Literature Search Strategy

This critical literature review aims to answer the above research questions using systematic and iterative approaches (Aveyard, 2010). Whilst a systematic literature review, with strict inclusion and exclusion criteria, may help to understand the body of knowledge about 'what works' (Jesson et al, 2011), this paper also aims to address some more complex, conceptual research questions. This critical literature review therefore takes the form of a traditional review, in which I aim critically to appraise existing knowledge (Jesson et al, 2011) and reformulate ideas based on this (Hart, 1998). Traditional literature reviews can still use systematic approaches (Jesson et al, 2011), but without strict inclusion and exclusion criteria. An iterative search strategy was employed in order comprehensively to access relevant empirical and theoretical literature. This has the benefit of allowing flexibility to explore ideas and add new and original conceptual insights on the topic (Jesson et al, 2011; Aveyard, 2010). However, the selection of material using this approach becomes implicitly subjective, and Jesson et al (2011) argue that it is, therefore, good practice to exercise transparency in how literature was selected.

Title contains:	Abstract contains:
• ASD OR ASC OR autis* OR Asperger*	• sensory • diagnos* • correlat* • sensory integration • sensory curriculum • sensory AND learning • sensory approach • curric* • educat*

*Table 1: Search terms used in literature search strategy. (*Note: the asterisk in Boolean logic shows results with any ending to the initial word stem, such that "autis*" would show results for "autism" and "autistic", which includes terms such as "autistic spectrum disorder/condition")*

Using Boolean logic, I employed various combinations of the initial search terms, shown in Table 1, to search ProQuest Social Sciences, a database cluster which searches several databases simultaneously, including (but not limited to) the British Education Index, Australian Education Index and PsycInfo. Searches were limited to peer-reviewed articles, but without limits on the date range or the nationality of articles, to reflect the development of research over time and the international background of research in this area. A 'snowball' method was then employed, as described by Jesson et al (2011), in which I searched for other papers from the same author and relevant references cited in the paper, as well as continuing new searches for keywords in the articles, and looking up related articles suggested by the publisher's database. All literature selected was judged to make a useful or relevant contribution to answering the research questions outlined above.

3. Research Question 1: Are sensory symptoms an essential diagnostic characteristic of ASC?

There is a longstanding conceptual debate as to whether sensory processing differences are an *essential feature* of autism, or whether they are co-morbid phenomena (Ben-Sasson et al, 2009). Whilst some authors argue that "sensory processing problems need to be considered part of the disorder" (Kern et al, 2007, p. 123), others argue that sensory processing differences are not inextricably linked and that caution should be exercised in how their link is understood (Wing et al, 2011). To address this issue, I will now describe current diagnostic criteria and critically discuss research into the prevalence and patterns of sensory experiences of people with ASC.

3.1 What do diagnostic criteria suggest?

Historically, diagnostic criteria for autism have always described stereotyped and restrictive or repetitive behaviours, such as rocking, hand flapping or spinning (Bogdashina, 2003). Pioneers Kanner

(1943, cited by Rogers and Ozonoff, 2005) and Asperger (1944, cited by Dunn, Saiter and Rinner, 2002) both described these behaviours in their early case studies. Current diagnostic manuals still refer to 'stereotyped repetitive behaviour' (World Health Organisation, 2010) and 'restricted, repetitive patterns of behaviour' (American Psychiatric Association, 2013). More recently, researchers have begun to theorise that these previously pathologised 'autistic behaviours' should be understood as compensatory, and even involuntary, strategies for coping with and regulating incoming sensory information (Bogdashina, 2003). This is reflected in the current version of the Diagnostic and Statistical Manual-Version Five ('DSM-V' hereafter), which recognises that sensory sensitivity, in the form of "hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment" may be one manifestation of the 'restricted, repetitive patterns of behaviour' criterion (APA; 2013, p.50). As a result, the DSM-V was criticised in its draft form for not clarifying the issue of whether sensory abnormalities should be included as an essential feature (Wing, Gould and Gillberg, 2011). Based on Wing et al's (2011) suggestion, this was resolved by an explanatory note in the published DSM-V which states that "extreme reaction to or rituals involving… [sensory experiences]… are common and may be a presenting feature of autism spectrum disorder" (APA, 2013, p. 54). This tentative wording indicates that sensory features are *not* currently considered an essential diagnostic feature, although some authors argue that high prevalence rates indicate that it should be: I will now appraise the research evidence.

3.2 Are sensory symptoms prevalent in all people with ASC?

Several studies report consistently higher prevalence of sensory symptoms in the ASC population. Findings suggest that up to 70% of children with ASC (n=679) were reported to have 'unusual sensory interests' and 66% were reported to demonstrate 'negative sensory responses' (Zachor and Ben-

Itzchak, 2013). Similarly, Klintwall et al (2011) reported that 76% of children with ASC (n=208) had a 'major abnormality' in at least one sensory modality. One study reported that as many as 95% of children with ASC (n = 281) demonstrated some aspect of sensory dysfunction using Dunn's Short Sensory Profile, which was significant when compared to age-matched typically developing peers (Tomchek and Dunn, 2007). Other studies report prevalence rates ranging from 69% (Barenek et al, 2006) to 90% (Leekam et al, 2007), which are significantly higher than both typically developing children and children with other developmental disabilities. In a meta-analysis of 14 studies, Ben-Sasson et al (2007) found highly significant differences in the presence of sensory symptoms in the ASC group compared to either typically developing groups or other developmental conditions. Contrary to this, one study proposed evidence of an ASC subgroup that do not experience sensory processing issues (O'Donnell et al, 2012). There is some degree of variation in these findings, which may be explained by methodological differences, such as the range of different measures used to assess sensory symptoms (this is discussed later). The findings do, however, clearly demonstrate that sensory symptoms are not universal in *all* children with ASC, although they are more likely to occur in this group.

3.3 Do distinct patterns of sensory processing in ASC distinguish this group from other developmental conditions?

Some authors argue that sensory abnormalities are distinguishing features of children with ASC (Wiggins et al, 2009), which is supported by evidence of significantly higher rates of sensory symptoms in the ASC population, compared to other developmental conditions (Barenek et al, 2006; Leekam et al, 2007; O'Brien et al, 2009). Contrary to this, in a review of 48 empirical papers and 27 theoretical papers, Rogers and Ozonoff (2005) concluded that, whilst children with autism tended to have more frequent and prominent sensory symptoms than typically developing children, these sensory

symptoms do not distinguish the ASC group from other developmental conditions. They found that in some studies, certain clinical groups (including Fragile X syndrome or deafblind children) had as many or even more sensory symptoms reported by parents. Leekam et al (2007) concluded that sensory symptoms are not *unique* to autism, but may be more prevalent in this group compared to other developmental conditions.

Other empirical evidence suggests that the ASC population may have distinctive patterns of sensory processing, which create a qualitative distinction from other developmental conditions. Although Leekam et al (2007) concluded that there is "still limited systematic evidence on the patterns of atypical sensory behaviours in autism" (p. 894), there is some evidence to suggest patterns may exist. Evidence suggests strengths and preferences in processing simple sensory stimuli (static, repetitive and predictable: for example, visual information is enduring), alongside difficulties with complex sensory stimuli (rapid, changing or unpredictable: for example, verbal or auditory information is transient) (Ashburner, Ziviani & Rodger, 2013). This is supported by Peeters (2000, in Powell, 2000), who argued that learners with autism tend to be stronger in processing concrete, visual and spatial information, and weaker in processing abstract, invisible and temporal information. Typical patterns of sensory symptoms in children with autism often relate to inattention and distractibility, sensory seeking, auditory sensitivity, and tactile sensitivity (Tomchek and Dunn, 2007). The ASC group may be distinguished from other developmental conditions by more tactile and taste/smell sensitivities as well as difficulties with auditory filtering (Wiggins et al, 2009). Higher rates of auditory hyper-sensitivity and visual stimulus-seeking behaviour have also been reported to distinguish between ASC and non-ASC clinical groups (O'Brien et al, 2009). Furthermore, there are consistent findings that sensory symptoms are reported across *multiple* sensory domains in children with autism, whereas comparison groups tend to have sensory symptoms in only one domain (Leekam et al, 2007). This is supported by evidence of patterns of sensory seeking across multiple sensory channels in children with ASC (Tomchek and

Dunn, 2007), and evidence that all sensory modalities tend to be affected in this population (Kern et al, 2007; O'Brien et al, 2009).

3.4 Summary

The reported prevalence rates of sensory symptoms in the ASC population are generally high (although varied), ranging from 66%-95%. Sensory symptoms do not, however, occur in *all* individuals with ASC, but are more likely to occur in the ASC population than in typically developing children. There is no consensus as to whether the *presence* of sensory symptoms distinguishes ASC from other developmental conditions, and some studies report sensory symptoms in children with other developmental conditions. In summary, ASC and sensory symptoms are not inextricably linked: sensory symptoms are not confined to autism, nor do they occur in all children with autism (Wing et al, 2011). There is consistent evidence, however, of qualitative differences: children with ASC tend to prefer concrete to abstract stimuli, and common difficulties relate to auditory filtering/hypersensitivity, visual sensory-seeking, and tactile and taste/smell sensitivities, as well as presenting with sensory symptoms across multiple modalities. In conclusion, sensory symptoms cannot be considered an *essential* diagnostic characteristic of ASC, but the high prevalence rates and specific patterns of sensory processing experiences warrant further review of the literature into the impact on learning and functioning for this group. Furthermore, the variation in findings is likely to arise from conceptual and methodological issues, which strengthens the need to explore the construct of 'sensory processing', including how it is described and measured. These issues will now be discussed.

4. Research Question 2: What is sensory processing and how does it affect learning?

4.1 What is sensory processing?

Classic Piagetian theory suggests that typically developing infants accommodate to their environment by creating perceptions by assimilating incoming sensory information. This may occur from seven sensory modalities: vision, hearing, olfaction, gustation and the tactile system, as well as the vestibular and proprioceptive systems, which are less commonly known. The vestibular system receives information from the inner ear about balance, movement and gravity (Bogdashina, 2003; Kranowitz, 2005). One type of vestibular receptor provides information about the body's position relative to the force of gravity; the other detects the speed and direction of head movements, which provides information about body movement, including speed and direction (Ayres, 2005). Finally, the proprioceptive system receives feedback from stretching and contracting muscles, tendons and joints about the body's position and posture (Bogdashina, 2003; Kranowitz, 2005).

In order to understand and interpret this incoming sensory information, that is to 'perceive' it, it must be processed. Sensory processing can be defined as "a person's way of noticing and responding to sensory events that occur in everyday life" (Dunn, 2008, p. 140). In order to use this information in a functional and meaningful way, the information from multiple sensory channels must be integrated (Larkey, 2007); this was termed 'sensory integration' by Ayres in the 1970s (Ayres, 2005). Furthermore, in order to gain meaning from these sensations and make functional responses to them, Bogdashina (2003) argues that sensory perceptions must link to cognitive associations stored in memory. Pellicano (2013) theorised that we understand sensory information by generating hypotheses based on our prior knowledge and experiences. These 'priors', she argued, help us to understand ambiguous information. The way in which sensory information is perceived by different people is, therefore, highly individual.

4.2 How are sensory experiences described and measured?

The literature reviewed throughout this paper uses a variety of different measures of sensory experiences, ranging from first-hand, anecdotal accounts (Ashburner et al, 2013) to in-depth sensory profiling tools, as well as single-item measures from diagnostic tools, such as the Autism Diagnostic Interview-Revised (ADI-R; Zachor and Ben-Itzchak, 2013). It appears that there is currently no agreed, definitive way to assess or measure sensory processing. The literature reveals two dominant in-depth measures of sensory processing: (i) the Sensory Profile (including the frequently used Short Sensory Profile;; Dunn, 1999, cited by Tomchek and Dunn, 2007) and (ii) the Sensory Experiences Questionnaire ('SEQ' hereafter; Barenek et al, 2006). They are grounded in slightly different theoretical perspectives, which will now be outlined.

Firstly, Dunn (1997, cited by Dunn, 2001) theorised that individual 'thresholds' describe the point at which sensations are noticed and responded to. She suggested four patterns of sensory processing relating to individual thresholds and self-regulatory responses: (i) *sensory seeking* occurs when there are high thresholds with active self-regulation – the person's actions seek to intensify sensory input to reach the threshold; (ii) *low registration* occurs when there are high thresholds but passive self-regulation – the person does not notice environmental stimuli and may appear uninterested or oblivious; (iii) *sensory sensitivity* occurs when there is a low threshold with passive self-regulation – the person tends to be hyperactive, distracted and easily upset; and (iv) *sensory avoiding* occurs when there is a low threshold and active self-regulation - the person seeks to reduce input and may withdraw or become irritable or aggressive (Dunn, 2008). Consequently, Dunn developed the 'sensory profile' (Dunn, 1999, cited by Kern et al, 2007) which is a 125-item questionnaire, using Likert scales to assess caregiver perceptions of sensory processing across all seven sensory modalities, as well as emotional, social and behavioural responses, and indicates thresholds for responding (Kern et al, 2007). The Short

Sensory Profile ('SSP' hereafter) was subsequently developed, based on the 38 items with the highest discriminatory power (Dunn, 1999, cited by Tomchek and Dunn, 2007). The SSP has been recommended for research protocols, based on its short administration time (ten minutes) and its value in measuring sensory atypicalities (Tomchek and Dunn, 2007). The SSP is commonly favoured in research (Ashburner et al, 2008; Lane et al, 2010, 2011; O'Donnell et al, 2012; Tomchek and Dunn, 2007; Wiggins et al, 2009) instead of the full sensory profile. Tomchek and Dunn (2007) argue that this is because the SSP isolates the items relevant to sensory processing and omits items relating to social-communication and motor development, although this rationale is not always explained in research articles themselves.

The second dominant measure of sensory processing was developed by Barenek et al (2006), who criticised the Sensory Profile and SSP for their lack of validity in discriminating sensory features in children with autism from those with other developmental disorders. Consequently, Barenek et al (2006) developed the Sensory Experiences Questionnaire ('SEQ' hereafter), which uses a similar 'threshold' model of hypo- or hyper- responsiveness. The SEQ also considers the context in which sensory experiences occur: social (such as tolerating others' physical contact) or non-social (such as noise or texture). The SEQ uses 21 items pertaining to caregiver perceptions of the child's responses to sensory experiences: these are divided into four mutually exclusive categories: hypo-social, hypo-non-social, hyper-social, hyper-nonsocial. Barenek et al (2006) reported satisfactory internal consistency, ease of use (rated by caregivers) and test-retest reliability. Within the scope of this review, only one other study used the SEQ, but the authors did argue that it is a "sound theoretical model" (Ausderau et al, 2014, p. 923).

These are not the only measures used: other studies have used systematic interview protocols, using items from the PARIS (Paris Autism in Research In Sib-pairs) schedule (Klintwall et al, 2011), or items

from the diagnostic tool, the ADI-R (Zachor and Ben-Itzchak, 2013). However, papers using sensory items within broader measures (such as the ADI-R) were excluded from Ben-Sasson et al's (2009) meta-analysis, which indicates their view that this is an inadequate measure of sensory symptoms. The construct validity across this literature is threatened by the poorly defined construct of 'sensory symptoms' and may explain the varied (and sometimes contradictory findings), such as the reported prevalence rates of sensory symptoms in ASC.

Most studies in this review rely on caregiver (or professional) report ratings, with the obvious limitation in the gap between the child's perception (input) and internal mental states (elaboration), and the observable behaviours (output) as subjectively interpreted by caregivers (see Feuerstein's phases of the mental act, Feuerstein and Lewin-Benham, 2012). Caregiver report methods may also be limited by cultural expectations: Caron et al (2012) found that American parents were more likely to report unusual sensory responses, especially difficulties with auditory filtering and visual/auditory sensitivity, than Israeli parents. Despite these issues, the current literature review only found one study that used self-report methods, using first-hand interview accounts (Ashburner et al, 2013). The authors argue that this is a valuable way to assess sensory processing experiences (Ashburner et al, 2013), though this is naturally limited to higher-functioning individuals, with the meta-cognitive and verbal skills to describe their experiences, which may account for the common use of caregiver/professional reports.

4.2 How do sensory experiences impact on learning and functioning for children with ASC?

Some responses to sensory experiences can also become dysfunctional, distressing or confusing for the individual. Sensory processing disorder, sometimes referred to as sensory integrative dysfunction (Ayres, 2005), is described as an umbrella term (Miller and Hepburn, 2004) for difficulties in sensory processing and is defined as difficulty in organising and using sensory information (Kranowitz, 2005). In her early work in the 1970s, pioneer Jean Ayres describes sensory processing disorder on three

levels: (i) the registration of sensory information may be over- or under- responsive; (ii) the modulation of sensory input may cause anxiety and discomfort; (iii) the integration of sensory information may be dysfunctional leading to disorganised perceptions of the environment (Ayres, 2005). Sensory integration is considered to be a naturally occurring process, involving the "organisation and processing of sensations from different sensory channels for meaningful use" (Larkey, 2007, p. 11). Ayres (2005) describes sensory integration as the process of turning sensations into perception; that is, the process of making meaning from sensations. She argued that children's capacity for learning was dependent on their ability to integrate sensory information and she suggested that difficulties with learning and behaviour can often be attributed to inadequate sensory integration (Ayres, 2005).

These sensory experiences may have a significant impact on learning and classroom functioning. Ayres (2005) argued that a child's capacity for learning is dependent on their ability to integrate sensory information successfully to form meaningful perceptions. Disrupted sensory processing is thought to interfere with organised and purposeful behaviours, which are considered the foundations for learning (Watling & Dietz, 2007). This is summarised by Jordan and Powell (1990, p. 7), who argued that, "the psychological effect [of perceptual differences] on learning may be significant". This is supported by empirical findings from Ashburner, Ziviani and Rodger (2008), who reported that children with ASC and auditory filtering difficulties who demonstrate sensory-seeking behaviours are more likely to underachieve academically. They reported potential explanatory links between certain sensory features: inattention to cognitive tasks may be explained by poor auditory filtering, whilst hyperactivity/inattention may be linked to tactile hypersensitivity, and oppositional behaviour may be explained by movement/vestibular sensitivity. Further evidence suggests that sensory processing difficulties may impact on classroom functioning, in that they can predict communication competence (Lane et al, 2010) and maladaptive behaviour (Lane et al, 2010; O'Donnell et al, 2012). Furthermore, Powell (2000) argued that potentials for learning in ASC may occur through multiple sensory channels,

which is supported by empirical evidence (Tomchek and Dunn, 2007; Kern et al, 2007; O'Brien et al, 2009).

4.3 Summary

Sensory processing occurs across seven modalities: vision, hearing, olfaction, gustation, and tactile, vestibular and proprioceptive systems; sensory integration refers to the process of making sense of this information from multiple sensory channels and is considered the foundation for learning. Evidence suggests that disturbances in sensory experiences can have a significant impact on learning and classroom functioning, which strengthens the rationale to consider best practice in addressing sensory needs. Caution should be exercised, however, to methodological issues arising in research in this area, particularly relating to issues of construct validity resulting from the poorly defined construct of 'sensory processing' and the consequent wide variety of assessment tools used to measure it.

5. Research question 3: How are the sensory needs of learners with ASC addressed in educational contexts?

5.1 Two schools of thought

There are two broad schools of thought concerning how to address the sensory needs of learners with ASC. The first takes a problem-focused, within-child perspective of sensory processing *difficulties*, suggesting that individualised interventions (such as 'Sensory Integration Therapy') are necessary to 'treat' this problem; the other takes a more systemic, holistic approach, suggesting that the educational environment and pedagogical strategies should seek to accommodate sensory processing *differences*. I will now discuss both approaches, drawing on theoretical and empirical literature.

5.2 Sensory Integration Therapy

Sensory Integration Therapy ('SIT' hereafter) is usually delivered by occupational therapists, using carefully selected 'therapeutic sensory experiences' and physical interaction in order to improve sensory integration, with the aim of improving learning, behaviour and quality of life (Ayres, 2005). The therapy offers the child structured opportunities for consolidation of sensory learning experiences in order to integrate information successfully to form useful perceptions. SIT is based on the assumption that neural pathways are strengthened with use, analogous to muscles becoming stronger with use. It aims to support the child in using 'as many synapses as possible' in order to use the brain more effectively and grow new interconnections (Ayres, 2005). Whilst this theoretical explanation may have face validity to parents and professionals with limited understanding of neuroscience, these reductionist explanations appear to be based on several assertions, which Ayres does not support with empirical evidence. At one point, she rather simplistically summarises that SIT helps the child to "organize his brain so that it will work better" (Ayres, 2005, p. 44). Ayres actually argues that "we know less about what causes sensory integration dysfunction than we know what to do about it" (Ayres, 2005, p. 50), summarising the dubious theoretical foundations of SIT.

Despite this, research into the efficacy of SIT for children with ASC is growing. Findings, however, are mixed. One recent pilot study, using a Randomised Control Trial, suggested that SIT for children with ASC may support progress towards personalised goals and decrease autistic mannerisms (Pfeiffer et al, 2011), although the authors argue a larger scale replication is necessary to draw valid and generalisable conclusions. Conversely, another study, which used a repeated case study design with four children with ASC, reported no efficacy of SIT on undesired behaviour or task engagement, when compared to a play-based intervention (Watling and Dietz, 2007). These outcomes were rated by the researcher, a research assistant and caregivers, with high reported inter-rater reliability (81-100%).

Despite these null findings, Watling and Dietz (2007) did report positive subjective caregiver reports, including positive reported effects on transitions, socialisation, compliance and behaviour regulation. These positive findings may be explained by demand characteristics or may reflect limitations of the measures used in showing positive outcomes. A recent systematic review of SIT targeted specifically at the ASC population also indicates mixed findings. Lang et al (2012) reported that, out of 25 studies reviewed, only three studies reported evidence that SIT was effective, whilst eight studies reported mixed results and 14 studies reported no benefits to SIT. The authors concluded that the current evidence-base does not, therefore, support the use of SIT in the education of children with ASC.

The reasons for these mixed findings may lie in methodological and design limitations. Lang et al (2012) reported that most studies in this area (including the three studies reporting positive results) had serious methodological flaws. This particularly relates to the fidelity of the intervention delivered (Lane and Lynn, 2011). This called for a manualised approach (Watling and Dietz, 2007; Lane and Lynn, 2011), which was developed by Parham et al (2007, in Lane and Lynn, 2011) and as a result 'Ayres Sensory Integration' is now trademarked. Recent evidence suggests that adequate fidelity in this manualised approach can be achieved (Schaaf, Benevides, Kelly, and Mailloux-Maggio, 2012). The authors concluded that SIT is considered to be safe, feasible, and acceptable by parents and therapists (Schaaf et al, 2012), although this paper provided no evidence of the *efficacy* of SIT. Despite this uncertain evidence-base, 'sensory integration' is listed as an autism-specific approach that is used in many schools (AET, 2011).

5.3 Holistic and systemic approaches

The second broad school of thought relates to addressing sensory needs through more holistic and systemic approaches, which better accommodate current political ideologies about inclusion. Davis

(2001, p. 21) argues that "it should not be necessary to withdraw pupils for individual programmes" and argues for a sensory *approach* to the curriculum, rather than a separate (additional) sensory curriculum. Other authors, who also challenge the targeted intervention approach, argue that sensory integration treatment frequency tends only to comprise two weekly sessions of thirty minutes (Sanderson and Gitsham, 1991), and people with ASC, in particular, may have difficulty generalising from these weekly interventions (Larkey, 2007). Instead, the holistic perspective assumes a 24-hour approach to sensory experiences (Sanderson and Gitsham, 1991), suggesting that sensory experiences are part of everyday life and should be embedded in naturally occurring opportunities in educational contexts (Dunn, 2008). This is supported by Davis (2001) who argues that a sensory curriculum can be delivered at any time, and Fowler (2007), who suggested that all activities in a person's life should be considered and presented in a sensory-stimulating way.

This approach seeks to reconceptualise 'sensory needs' as a preference or learning style. The focus is on changing the environment and pedagogical strategies, instead of necessitating the child to adapt to the school environment (Dunn, 2008). Furthermore, some authors have begun to acknowledge the strengths and preferences of learners' sensory profiles (MacKenzie, 2008), which can be positively accommodated in pedagogical styles and curriculum delivery. In adopting a strengths-based approach, Dunn (2008) argues that we should ensure that sensory experiences are mediated to optimise learning, rather than trying to 'treat' or 'cure' them. Supporters of this approach argue that instead of aiming to 'cure' a student of sensory 'difficulties' and change their sensory processing patterns, we should focus on adapting the curriculum, with the aim of improving participation (Dunn, 2008). This attitude is supported by good practice guidance, which suggests that we should aim to adapt the NC, through differentiation, individualised programmes, modifications to delivery and the use of autism-specific approaches (AET, 2011). This indicates scope for developing and empirically testing such approaches, in order to add more specific recommendations to good practice guidance.

5.4 Summary

The literature reveals two main approaches to understanding and meeting sensory needs. The first conceptualises sensory needs as a *difficulty* that needs to be treated with a separate, targeted intervention, Sensory Integration Therapy. SIT can be reliably delivered with fidelity, but there is a lack of consistent evidence showing the efficacy of SIT for children with ASC. The second, more holistic approach seeks to understand sensory needs as a *difference* that should be accommodated by adaptations to the pedagogical style and curriculum delivery. There is a call for further research to develop an evidence-base for such holistic strategies.

6. Implications

6.1 Implications for parents, professionals and good practice guidance

This paper contributes to an increased understanding, for parents and professionals alike, of possible presentations of sensory symptoms in children with ASC. This increased awareness can support the recognition and referral of children with possible ASC and/or sensory symptoms, with the understanding that the two are not inextricably linked. With improved understanding, parents and professionals may be better able to reframe commonly reported classroom difficulties with the consideration of underlying sensory explanations (Ashburner et al, 2008).

Additionally, I have outlined the impact of sensory symptoms on learning and functioning for children with ASC. There is a risk of academic underachievement (Ashburner et al, 2008), poor communication competence (Lane et al, 2010) and maladaptive behaviour (Lane et al, 2010; O'Donnell et al, 2012). It is of paramount importance, therefore, that parents and professionals take action to maximise sensory

learning opportunities and minimise sensory barriers to learning. Currently, SIT is recommended, but this targeted approach has an ambiguous evidence-base (Lang et al, 2012; Pfeiffer et al, 2011; Watling and Dietz, 2007). There is scope for developing and researching more holistic and systemic sensory approaches to adapting the school environment and pedagogical strategies. Another principal aim of this paper was to synthesise existing knowledge about sensory processing in ASC, in order to inform good practice guidance. The key recommendations are shown in Box 1.

Box 1: Key recommendations for updating good practice guidance:

1. To update simplistic descriptions of over- or under-sensitivity (AET, 2011; Charman et al, 2011; NICE, 2011; DCSF, 2009) to include all possible patterns of sensory processing. This should include an explanation of threshold theories, including Dunn's (2008) patterns of sensory seeking, low registration, sensory sensitivity and sensory avoiding, as well as Barenek et al (2006)'s distinction between social and non-social sensory stimuli.
2. To acknowledge that all sensory channels may be affected (not just visual and auditory channels) and to explain less commonly-known senses such vestibular and proprioceptive systems
3. To communicate this information to practitioners, by updating the AET's guide for teachers (AET, 2011) to include the above information
4. To reframe the notion of "reducing sensory issues" (DCSF, 2009, p. 12) to develop more positive, strengths-based strategies for learning using sensory preferences
5. To make more specific recommendations for best practice in *how* to support learners with ASC and sensory symptoms, such as specific environmental adaptions to accommodate the child's sensory experiences across the range of modalities and sensory processing patterns. (This is likely to require a period of further research).

6.2 Implications for research

Despite the conclusion that sensory symptoms are not a diagnostic characteristic of ASC, the literature reveals a strong prevalence of sensory processing differences in people with ASC. Though it was

beyond the scope of this review, it is important to consider *why* and *how* these two conditions are so consistently linked. An indication that there is no satisfactory psychophysiological explanation of why sensory symptoms occur in autism (Rogers and Ozonoff, 2005) warrants further theoretical discussion, synthesis of existing research and further hypothesis-testing empirical research. There is also a need for a stronger theoretical explanation of the link between observable 'sensory behaviours' and internal perceptual and processing systems. Measures that rely on subjective caregiver interpretations of observable behaviour at the output phase, may not be the most useful way to address the *why* and *how* questions. Based on preliminary findings from self-report descriptions of sensory experiences (Ashburner et al, 2013), there may be scope for more qualitative ways to understand sensory experiences. Further research using detailed first-hand accounts may help to understand how sensory experiences operate at each phase of the mental act (input-elaboration-output; Feuerstein and Lewin-Benham, 2012).

Furthermore, I have discussed methodological challenges in assessing and measuring sensory processing, particularly the poor construct validity ensuing from inconsistent definitions. There is scope for further larger-scale research to establish a clear definition of 'sensory processing' and to improve the construct validity of such measures. Regarding interventions and strategies for supporting sensory needs in the classroom, this paper highlights a gap for research to develop and evaluate holistic approaches, as an alternative to SIT. With their research skills-base, Educational Psychologists may be well-placed to offer further empirical research and theoretical insights in this area. Whilst many references in this paper come from the field of occupational therapy, research can benefit from a collaborative multi-professional approach: Lane and Lynn (2011, p.3) argue that "there is far too much to understand about these disorders to rely solely on any individual profession".

7. Conclusion

From this critical literature review, I conclude that sensory symptoms are not an essential diagnostic feature of ASC: research indicates high prevalence rates, but they are not *universal* in ASC, nor are they *unique* to ASC. I have critically discussed the conceptual and methodological issues in measuring and assessing sensory processing, and I conclude that, until construct validity improves, research should be interpreted with caution. I have also outlined theories about sensory processing, as well as depicting research describing the common patterns of sensory processing in children with ASC and the effects on learning. This carries important implications for parents and professionals in recognising and understanding sensory explanations of common classroom difficulties, as well as implications for updating good practice guidance. The potential negative impact of sensory processing differences on learning for children with ASC warrants further consideration of best practice for addressing these sensory needs. Despite its questionable theoretical grounding and ambiguous evidence-base, Sensory Integration Therapy is still recommended in good practice guidance (AET, 2011). Some authors argue for a more holistic approach to adapting the environment and pedagogical strategies, but this highlights a need for further research to develop the evidence-base.

In summary, this review offers a synthesis of existing literature in relation to the sensory experiences of children with ASC, which has informed an understanding of their patterns, prevalence and diagnostic status. I have made some key recommendations for updating good practice guidance, whilst highlighting the need for further research to develop ways of *addressing* sensory symptoms in educational contexts.

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PPR1 Appendix 1: Note on terminology

i. *Autistic Spectrum Condition* - The notion of autism laying on a 'spectrum', rather than a discrete categorical disorder, was introduced by Lorna Wing in 1992 (Wing, 1995). 'Autism Spectrum Disorder' since became an umbrella term to describe individuals with these set of symptoms on a continuum of severity. Subsequently, several authors have begun to embrace the 'difference not deficit' conceptualisation of autism, and now prefer to use the term 'Autistic Spectrum *Condition'* (Baron-Cohen, 2008). In this paper, I prefer the use of the term 'Autistic Spectrum Condition' ('ASC' hereafter), but also use the term 'autism' interchangeably, as still commonly used as an umbrella term in the literature.

ii. *Sensory Processing Differences* - The term 'difference' (rather than 'difficulty') is being increasingly used to describe individuals' sensory experiences (Bogdashina, 2003). This seeks to move away from the deficit model, which is currently echoed in the problem-focused language of 'good practice' guidance: for example, suggesting that practitioners should seek to "reduce sensory issues" (DCSF, 2009, p. 12). The term 'sensory processing differences' acknowledges potential strengths and preferences of learners' sensory profiles (MacKenzie, 2008) and recognises that that sensory idiosyncrasies may be experienced as positive and unproblematic. Whilst I prefer the philosophical underpinning of this term and have sought to use it, I have also frequently referred to [sensory] 'experiences', 'needs', 'symptoms', 'abnormalities' and 'difficulties' as a reflection of the terms used throughout the literature.

CHAPTER THREE

PROFESSIONAL PRACTICE REPORT TWO

~~WHOSE PROBLEM?~~ EVERYONE'S SOLUTION. A CASE STUDY OF A SYSTEMIC, SOLUTION-FOCUSED APPROACH TO THERAPEUTIC INTERVENTION IN A SECONDARY SCHOOL

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PPR2: ~~WHOSE PROBLEM?~~ EVERYONE'S SOLUTION. A CASE STUDY OF A SYSTEMIC AND SOLUTION-FOCUSED APPROACH TO THERAPEUTIC INTERVENTION IN A SECONDARY SCHOOL

Abstract

In this Professional Practice Report, I describe and reflect upon my application of a Solution-Focused Brief Therapeutic Intervention to support a 12-year-old boy presenting with externalising behavioural difficulties, in conjunction with solution-focused consultation with the school staff working with him. I provide an overview of the history and development of SFBT, and describe the philosophy, principles and techniques of the approach. I discuss the literature describing its application in schools and critically evaluate the research evidence about its effectiveness with young people. This case study highlights multiple issues in therapeutic work for educational psychologists, including debates about evidence-based practice (and practice-based evidence), as well as the role of assessment and formulation, ethical considerations, intervention fidelity, and ways to assess outcomes and evaluate the impact of educational psychologist involvement. With reference to its title, this case study particularly emphasises the value of systemic approaches in educational psychology casework; it highlights the role of school stakeholders in promoting and enhancing positive change when solution-focused brief therapy is undertaken with students.

1. Introduction

Jayden[1] was initially referred to the Local Authority's multi-agency support services at the age of 8, due to concerns with his attention and working memory and the impact of this on his learning, particularly in literacy. Following assessment, support and advice from the area SENCo (Special

[1] All names have been changed to protect the identity and confidentiality of service users.

Educational Needs Coordinator) and educational psychologist ('EP' hereafter), he received a Statement of Special Educational Needs; his main area of need was originally identified as cognition and learning. At the start of Year 8, Jayden's secondary school SENCo requested additional EP involvement in relation to concerns about his behaviour. He was described as "highly sociable and very energetic", which often resulted in him becoming over-excited and frequently getting "caught up in others' problems". Staff also expressed on-going concerns about Jayden's attention and off-task behaviour in lessons.

During an EP service planning meeting, Jayden was identified as a priority case (due to risk of exclusion) and the SENCo requested individual therapeutic work with him. Whilst the school wanted individual level work, it seemed appropriate to intervene at multiple levels of Jayden's 'system' (see Section 2.3). We agreed that I would lead some solution-focused consultation work with staff, as well as an individual intervention with Jayden, using Solution-Focused Brief Therapy. The rationale for this is discussed throughout.

2. Literature Review

2.1 Search Strategy

I employed an iterative search strategy, initially to search for books on the theory and practice of solution-focused approaches, using the University of Birmingham's library catalogue. This involved keyword searches for "solution-focused" and "solution-focused brief therapy" and an author search for "de Shazer". I also sought additional literature from an online book retailer, using similar search criteria. Next, I sought empirical research papers, from 'PsycINFO' and 'ProQuest Social Sciences' databases, using keyword and title searches with the following search terms in various combinations:

"solution-focused", "solution-focused brief therapy", "school*", "behaviour", "externalis*", "educational psycholog*", "systemic*" and "consultation". Using Boolean logic, search terms marked with an asterisk return results with all versions of the word stem. (For example "school*" would also return findings including the term "schools" and "schooling"). My iterative approach allowed flexibility to look up further references cited in these initial books and articles.

2.2 The Development of Solution-Focused Brief Therapy

Solution-focused brief therapy ('SFBT' hereafter) originated in the 1980s from research carried out by therapists at the Brief Family Therapy Centre, Milwaukee, Wisconsin (Iveson, 2002). The approach is rooted in family systems approaches, which is discussed more fully in Section 2.3. It is based on a deductive model of seeing 'what works' and then describing it in detail (de Shazer and Berg, 1997). The underlying research question has always been: "What works in brief therapy?" and this has been explored through hours of clinical observations and data collection seeking to establish which therapeutic techniques are successful in leading to behavioural change (Lipchik et al, 2012).

This team of researcher-therapists discovered that clients could make positive changes through extended conversations about their preferred future, and reported a reduced need to understand clients' problems in order to solve them (O'Connell, 2003). Thus the characteristic feature of 'solution-building' rather than 'problem-solving' emerged (O'Connell, 2005; Iveson, 2002). In contrast to traditional therapeutic approaches that focus on current problems and past causes, SFBT focuses on current resources and future hopes (Iveson, 2002). Therapists reported that, in using this approach, clients made good progress and felt empowered by talking about their preferred future, rather than their problem-laden past (O'Connell, 2005).

The development of SFBT is often attributed to Steve de Shazer, Insoo Kim Berg and Bill O'Hanlon (O'Connell, 2003), although de Shazer (1982) suggests that the ownership of ideas is a strange concept. He describes how the SFBT model has developed over time and cannot readily be accredited to any one individual. In particular, de Shazer (1982) acknowledges the influences of Bateson's ideas about systems (discussed in Section 2.3), as well as Erikson's principle of 'utilisation': advocating the use of the client's own strengths and resources, which he later describes as 'the key to brief therapy' (de Shazer, 1985, p. 6).

The SFBT model adopts a strengths-based approach, which seeks to identify and foster the conditions necessary to achieve the preferred state (de Shazer, 1985). Using the principles of 'if it works, don't fix it' (de Shazer, 1985) and 'if it's working, keep doing it' (O'Connell, 2005), therapists also seek to elicit times when the client is already achieving their goal and exceptions to the problem (de Shazer, 1988). These techniques are thought to identify the differences that can be 'put to work' (utilised) to make the client's life more satisfactory (de Shazer, 1991). Therapists began to focus on the questioning process and how to elicit ideas for change (O'Connell, 2005). Specific and standardised questioning and elicitation techniques have been developed: these are described by several authors and are summarised in Table 1.

Table 1: Techniques in Solution-Focused Brief Therapy

Technique	Description	Purpose(s)	Cited by (Authors)
Problem-free talk	The therapist seeks to demonstrate interest in the *person*, not just their problem.	• Rapport-building • Promotes a collaborative relationship	O'Connell (2003) O'Connell (2005) George et al (1999)
Identifying best hopes /aims	The client and therapist negotiate the preferred outcomes and aims of therapy. *Example questions:* • *"What would be different…?"* • *"How will we know if these sessions are useful?"* • *"How will …[insert person's name]… know that things are different/better?"*	• Seeks to establish clear and shared goals	Iveson (2002) George et al (1999)
The Miracle Question	This unusual technique has four key parts: 1. Overnight, a miracle happens. 2. The miracle solves the problems that brought the client to therapy. 3. The client has been asleep so does not know that the miracle has happened. 4. The discovery begins – how does the client begin to realise that something has changed? (Explored in detail)	• Elicits a rich and detailed description of the preferred future	De Shazer (1988) Iveson (2002) O'Connell (2003)
Scaling Questions	Asks the client to create and define points on a scale of 0-10, where 0 represents the worst possible scenario and 10 represents the preferred future (the miracle).	• Seeks to ensure that goals are realistic and achievable	Iveson (2002) O'Connell (2003)

	Scaling may also include separate assessments of the client's confidence and motivation to change.	• Provides a personalised and co-constructed measure of progress and/or desired outcomes	George et al (1999)
Coping and eliciting exceptions	The therapist uses curiosity to elicit the client's strengths and resources. This is sometimes known as 'pre-session change'. *Example questions:* • *"Is there a time when you don't…?"* • *"How do you do it?"* • *"How do you stop the problem from getting worse?"* • *"What do you already do to help yourself?"* • *"How do you cope?"* • *"What have you found useful/helpful so far?"*	• Seeks to identify the conditions necessary for positive change • Seeks to empower the client to notice what they are already doing and how they can help themselves	Iveson (2002) O'Connell (2003) George et al (1999)
Therapeutic compliments and constructive feedback	The therapist gives a useful summary of the session, including compliments about the client's strengths and resources.	• Strengthens the therapeutic relationship • Empowers clients to notice and utilise their own strengths and resources	Iveson (2002) O'Connell (2003) O'Connell (2005) George et al (1999)
'Noticing'	The therapist invites the client to notice any improvements between sessions, and to notice what they are doing when things are better.	• Sets expectations for positive change (engendering a positive self-fulfilling prophecy) • Empowers the client to observe their strengths and resources, and their ability to change	George et al (1999) De Shazer (1985)

2.3 Working Systemically as an Educational Psychologist

SFBT is clearly positioned as requiring a systemic epistemology; it was originally developed as a family therapy, in which families are regarded as systems (de Shazer, 1982). De Shazer (1982) acknowledges that the model draws upon Bateson's ideas about systems as sets of interacting parts, which mutually influence each other in complex ways. De Shazer (1985) suggests that only a small and reasonable goal is necessary, on the basis that one small change can lead to other changes in the system. This is rooted in the systemic view that if one significant part of the system begins to change, the rest of the system begins to change (George et al, 1999) and that "a small change in *any* part of a system (such as a person, perception, or behaviour associated with the problem) can ripple into larger changes" (Murphy, 1996, p. 185).

Ideas about 'systems thinking' and 'working systemically' are not new to educational psychology: Fox (2009) reports attempts to prevent pathologising children by working with their family system and by promoting whole school development work, including INSET (in-service training), action research, organisational development and consultancy. Fox (2009) describes two current examples of ways for EPs to apply systemic thinking to practice, both of which have been applied to the current case study: (i) consultation, when used as collaborative process to reframe problems and co-construct solutions; and (ii) individual work, particularly where this utilises SFBT.

Although SFBT is gaining popularity with EPs (Redpath and Harker, 1999), it is still often focused on individuals. Pellegrini (2009) warns that the focus must remain *systemic*, in order to avoid being drawn into 'within-individual' problem narratives and diagnostic frameworks. On a practical level, it follows that EPs should consider the student (and the reason for their referral) as part of a complex, interacting system of people, events and contexts, including teaching staff, parents and peers, as well as wider school, home and community influences. This ecological and systemic view offers pragmatism and

flexibility to choose what aspect of the focus issue to address and who (in the system) to work with (Murphy, 1996).

The literature suggests ways to promote effective systemic working when using solution-focused approaches. Firstly, it is important to consider how different stakeholders perceive the situation (Beaver, 2011), and to identify goals for change from both the young person and the school staff (George et al, 1999). This raises important questions: 'who is the problem holder?' and 'who is the client?' The title of this paper, '~~Who's problem?~~ Everyone's solution' seeks to draw attention away from ownership of the problem, and suggests that intervention should be collaborative, systemic and solution-focused. It draws on the idea that the pupil *and the school staff* have a role to play in making positive changes, not just the EP 'fixing' the student through therapy.

Secondly, in order to engender a 'virtuous spiral of change', the system must recognise and reward small changes made by the individual (Beaver, 2011). De Shazer (1985, p. 137) tellingly wrote "change is not only possible, but inevitable", arguing that the key to change is to get clients to notice improvements to the situation (in this case, referring to both Jayden *and* school staff). Ratner (2003) recommends the therapist having close contact with school staff in order to share progress. When staff are requested to feed back about positive changes, this encourages them to notice even the smallest improvements or signs of progress (George et al, 1999). This is reported to lead to a decrease in students complaining that nobody notices when they are good (George et al, 1999) and can also have a positive impact on school staff (Williams, 2000). Furthermore, a positive 'ripple effect' can occur as a result of consultations lead by therapists who have more optimism and higher expectations, as a result of using solution-focused approaches (Williams, 2000).

2.4 Rationale and Evidence-base for SFBT in Schools

2.4.1 SFBT in schools

Although SFBT began in family therapy, several authors describe its wider applications, including intervention for children and school students (Murphy, 1996; George et al, 1999; Ratner, 2003; O'Connell, 2003; O'Connell, 2005). The SFBT approach is considered to be well-suited to use in schools, due to its practical, time-limited approach (Murphy, 1996; Rhodes, 1993). From his own experience, O'Connell (2005) reports that, due to its simplicity, discipline and short timescales, SFBT is welcomed in schools where time and resources are often limited.

The application of SFBT in schools has grown in recent years and has been applied to a number of behavioural and academic problems (Kim and Franklin, 2009): the most commonly reported referrals are for behaviour issues, including those which place students at risk of exclusion (Ratner, 2003). Based on two recent review papers of SFBT applied to behaviour problems (Corcoran and Pillai, 2009; Kim, 2008), Corcoran (2012) concludes that there are four reasons why SFBT is particularly recommended for externalising behaviour problems: (i) it offers strategies to support students at all levels of readiness to change; (ii) its solution-focused philosophy is preferable to dwelling on problematic histories of failure, disappointment and frustration; (iii) it is more hopeful and empowering because it targets specific, concrete behaviours, rather than diagnostic labels and; (iv) it offers achievable, realistic, small and concrete goals for behaviour change.

2.4.2 SFBT Effectiveness

In addition to this rationale, the literature search revealed empirical findings and research reviews evaluating SFBT. One of the first critical reviews of controlled outcome studies for SFBT was reported

by Gingerich and Eisengart (2000). This paper included 15 studies, which were critiqued and classified using American Psychological Association standards (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, cited by Gingerich and Eisengart, 2000). Findings revealed that five studies were rated as 'well controlled' and revealed positive outcomes of SFBT, whilst ten studies were classed as 'moderately' or 'poorly' controlled, but still demonstrated positive therapeutic outcomes. Kim (2008) sought quantitatively to evaluate the effectiveness of SFBT using a meta-analysis of 22 studies, and concluded that SFBT has small but positive treatment effects for internalising and externalising behaviour problems and family and relationship problems. Kim (2008) concluded that more outcome studies should publish sufficient statistical information to calculate effect sizes, although this quantitative approach is not supported by all SFBT researchers. Gingerich and Peterson (2013) highlighted the limitations of using meta-analytic techniques to evaluate the effectiveness of SFBT, suggesting that the variability in SFBT techniques and the diverse range of populations and problems are too great to produce meaningful outcomes. Instead, Gingerich and Peterson (2013) chose to undertake a systematic qualitative review, arguing for its practical value to practitioners resulting from its transparency in describing how the intervention was used and enabling readers to judge the appropriateness of outcome measures. Including SFBT interventions for all client groups and issues, they reported that 32 out of 43 studies (74%) revealed significant positive benefits of SFBT and a further ten studies showed 'positive trends' (Gingerich and Peterson, 2013).

Empirical research has sought to explore the efficacy of SFBT in schools and with young people presenting with a range of behaviour-related issues, and indicates generally positive findings. In one study, SFBT was used with 67 individual students in school and led to significant self-reported improvements in externalising behaviours, as well as teacher-reports of improvements to internalising and externalising behaviours (Franklin et al, 2008). This finding is echoed by Wilson (2005): seven out of eight students, who had already experienced multiple exclusions, rated their situation as 'much improved' following SFBT, and teachers rated significant changes to their behaviour, as well as a

reduction in exclusions and reported behaviour incidents. Further evidence suggests that using group SFBT for students at risk of behavioural, social or academic failure can have positive impact on behavioural, emotional and social outcomes, as measured by the 'Social Skills Rating System', the 'Behavioural and Emotional Rating Scale' and the 'Homework Problem Checklist' (Newsome, 2005). This finding was triangulated between therapist, teacher and parent ratings, although the researcher omitted to gather feedback from the students themselves, which appears to undermine the principle of empowering the client (see Section 4).

Reviews of SFBT interventions in schools or with children and young people, also tend to draw positive conclusions. Approximately one third of the studies reviewed (14 out of 43) by Gingerich and Peterson (2013) were in the field of child behavioural and academic problems, and most had significant positive benefits or at least positive trends. Previously, Kim and Franklin (2009) identified and reviewed seven SFBT studies that were conducted in school settings or with students, and found mixed results, leading to tentative conclusions that SFBT may be useful for behavioural problems and 'at risk' students. More recently, Bond et al (2013) reviewed research into the use of SFBT with children and families. They included 38 studies, comprised of those addressing internalising problems (n=9), externalising problems (n=15), both internalising and externalising problems (n=3), and other issues (n=9), and concluded that findings are generally supportive of SFBT. A systematic review of eight single case-study design studies revealed more mixed findings: Kim (2012) reported that SFBT was highly effective for externalising behaviour problems (five studies), but only mildly effective or ineffective for internalising behaviour problems (two studies) and for family and relationship problems (two studies).

2.4.3 Evidence-Based Practice and Practice-Based Evidence

Despite these generally positive research findings, most authors seem to draw cautious and tentative conclusions, suggesting that SFBT has an 'emerging' evidence-base (Kim et al, 2009), or that findings

are ‘tentative’ (Bond et al, 2013), ‘promising’ (Kim and Franklin, 2009) or offer only ‘preliminary support’ (Gingerich and Eisengart, 2000). It seems that researchers tend to draw tentative conclusions in light of reservations about the *quality* of available research. Many authors argue that further research is needed (Murphy, 1996; Bond et al, 2013; Kim, 2008; Kim and Franklin, 2009; Kim et al, 2009), particularly suggesting a need for ‘stronger’ and ‘more rigorous’ methodologies (Gingerich and Eisengart, 2000; Kim, 2008; Kim et al, 2009; Corcoran, 2012) in order to establish a ‘strong evidence-base for SFBT’. This raises the question: how should SFBT effectiveness be researched?

The concept of ‘evidence-based practice’ originates from the field of medicine and has more recently been applied to the fields of psychology and education. The basic principle is that practice decisions are made according to rigorous analysis of the most up-to-date research evidence, rather than practitioners relying on their own knowledge, experience and word-of-mouth from others (Marks-Woolfson, 2011). The literature acknowledges the increasing demands and pressures to follow the best evidence-based practices (Franklin et al, 2012) and to choose therapeutic interventions with research support (Kim et al, 2009).

In the SFBT literature, definitions of evidence-based practice often emphasise the integration of research evidence with clinical and professional expertise, as well as individual client values, preferences and circumstances (Lipchik et al, 2012; Franklin et al, 2012). This perspective considers the judgement of skilled therapists and gives credibility to ‘practice-based evidence’ (Franklin et al, 2012), which is how SFBT was originally developed at the Brief Family Therapy Centre (Lipchik et al, 2012). SFBT research has always sought to establish ‘what works’ (de Shazer and Berg, 1997; Lipchik et al, 2012) and SFBT therapists have been more interested in the process of doing effective therapy, than seeking to ‘prove’ its worth as an empirically supported treatment (Franklin et al, 2012). Lipchik et al (2012) note that SFBT originated before concepts of EBP and has only recently been studied through the lens of evidence-based practice.

Perhaps authors criticising the lack of methodological rigour in SFBT evaluation research have shown preference towards positivism and traditional 'scientific methods' including experimental designs and randomised control trials, whilst it might be argued that SFBT research requires a different, more practice-based 'lens' to study its effectiveness (Lipchik et al, 2012). The American Psychological Association standards (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, cited by Gingerich and Eisengart, 2000) are commonly used as a basis for evaluating the 'quality' of SFBT research (Gingerich and Eisengart, 2000; Kim, 2008), but Table 2 outlines my critique of applying these standards to SFBT research.

*Table 2: Commentary on the inappropriateness of APA guidelines for evaluating SFBT (*Task Force on Promotion and Dissemination of Psychological Procedures, 1995, cited by Gingerich and Eisengart, 2000*)*

	***A*PA standard**	**Critique in Relation to SFBT**
1.	Use of randomised group design or 'acceptable' single case design	Despite the prestige associated with randomised group designs, this is not always feasible in real-world contexts. Most SFBT evaluation research actually comes from real-world research, rather than clinically controlled research (Lehman and Patton, 2012). Furthermore, it is not always appropriate to have control or comparison groups – see standard six below.
2.	Focus on a specific well-defined disorder	The solution-focused approach and philosophy of SFBT tends to oppose diagnostic labels and past causes (O'Connell, 2003; O'Connell, 2005; Murphy, 1996; Corcoran, 2012), instead focusing on solutions and problem-free futures. This is discussed more fully in Section 3.1
3.	Use of comparison group (standard reference treatment, placebo or no treatment)	SFBT has never been interested in whether it works 'as well as' or 'better than' other approaches (de Shazer and Berg, 1997). It appears that the comparative element, which is often insisted upon as a quality hallmark, is not always necessary to assess 'what works' in SFBT. In addition, SFBT actually promotes

		making small, modest and realistic changes: it is therefore not appropriate to try to make quantitative comparisons with other therapies and treatments.
4.	Use treatment manuals/procedures for monitoring adherence (fidelity)	Whilst fidelity to the approach is regarded as important, the extent to which SFBT techniques can be manualised is debatable. It seems that SFBT relies more on skilful application of the techniques, which are individualised to the client. This is discussed further in Section 3.5.
5.	Use outcome measures with demonstrated reliability and validity	Proponents of SFBT argue that the approach seeks to improve outcomes for the client, based on specific, *individual* goals, agreed between therapist and client. These may not be measured easily by standardised measures, nor may they always demonstrate discriminatory power before and after therapy, due to the focus on small, concrete changes. See Section 4 for a more detailed discussion.
6.	Use a sample large enough to detect group differences reliably	This is not relevant to single case study designs, which are advocated by several authors (Murphy, 1996; Kim, 2008) and should not be discounted as contributing to the 'evidence-base'. As above, individual goals may not be comparable between groups: the approach to evaluating SFBT should be comparing pre- and post- therapy 'measures' (assessment information), rather than comparing to other individual clients or client groups.

In summary, I caution against SFBT researchers and practitioners becoming trapped by the dominant positivist ideals surrounding evidence-based practice and 'quality research'. In SFBT, it is important to take a more pragmatic approach to establishing 'what works' and acknowledging the value of practice-based evidence. In answer to the question about how SFBT should be researched, there is scope to move away from asking 'does SFBT work?' and 'does it work better than [alternative]?' and instead

ask 'how does SFBT create the best outcomes for the client?' which is more in-keeping with the original development of SFBT. There is a role for future research to focus on change processes, in order to establish which techniques are best suited to which clients and to explore the circumstances under which the techniques will have the most benefit (McKeel, 2012).

2.4.4 Philosophy and Values of SFBT

As well as the rationale for the use of SFBT for externalising behaviour problems, which is clearly appropriate to Jayden's referral, the philosophy and approach of the SFBT model appeals to me for several reasons. Firstly, the overall approach of SFBT is compatible with my philosophical assumptions: the model takes a post-structuralist view that versions of truths are not objective discoveries, rather they are socially negotiated, with language (talking) as the instrument of *change* (O'Connell, 2003). This philosophy underpins the positive reframing of the 'focus issue' from dwelling on past problems to emphasising current successes (exceptions, strengths and resources) and solutions to achieve a preferred future state. Similarly to Rhodes (1993), I am drawn to the modest and highly practical approach of SFBT, which does not seek to explain or understand the reasons for 'problems', instead focusing on small, realistic and even 'imperfect' solutions.

Furthermore, I attach strong value to the emphasis on rapport-building, 'problem free talk' and identifying client strengths and resources: this is considered to be encouraging and respectful to clients (Rhodes, 1993), as well as empowering (O'Connell, 2005). Reciprocally, SFBT is reported to be a positive experience for therapists: O'Connell (2003) reports professionals' views that the approach energises and motivates them, giving them a sense of purpose and value, and offers them renewed hope and optimism by focusing on the client's strengths, personal qualities and future-focused solutions.

Concluding from this literature review, I chose to approach this casework in a systemic and solution-focused way, by working alongside school staff (through consultation, regular follow-up discussions and written feedback), as well as conducting an individual SFBT intervention with Jayden.

3. Intervention

I now describe my application of the SFBT intervention and use of solution-focused consultation in this casework, and reflect upon the key issues raised with reference to the literature.

3.1 Assessment and Formulation

Using this case as an example, I reflect on the role of assessment and formulation in SFBT. Traditional scientist-practitioner models for EP casework have embraced a cyclical process of 'assessment, formulation, intervention and evaluation' (HCPC, 2012), but proponents of solution-focused approaches question whether these stages are all necessary, or indeed clearly distinguished (O'Connell, 2005). Some solution-focused texts claim that assessment is unnecessary because therapists can supposedly work with anyone and any issue (O'Connell, 2005), and at any level of readiness to change (Corcoran, 2012). Others acknowledge that assessing the client's readiness to change can be used to shape the intervention (O'Connell, 2005).

'Readiness to change' was described by de Shazer (1988) in relation to three different types of client (i) 'visitors', who do not see a problem and/or do not want to be in therapy; (ii) 'complainants', who are willing to discuss the problem, but show ambivalence about acting to achieve change; and (iii) 'customers', who recognise a problem and want to change. O'Connell (2005; Table 3) drew parallels

between these client descriptors and the stages of behaviour change described in Prochaska and Diclemente's (1982) comprehensive model, known as the Trans-Theoretical Model (TTM). The TTM describes a process of behaviour change, in which the verbal processes of considering change (contemplation and determination) form an important pre-requisite for the behavioural processes of preparing for and committing to action (action and maintenance) (Prochaska and Diclemente, 1982). The model also acknowledges that progress is not linear, and relapse is possible (O'Connell, 2005). Many solution-focused practitioners have found this model useful (O'Connell, 2005); SFBT, as a future-focused talking therapy, is ideally positioned to enable clients to move from the pre-contemplation or contemplation stages through to committing to action.

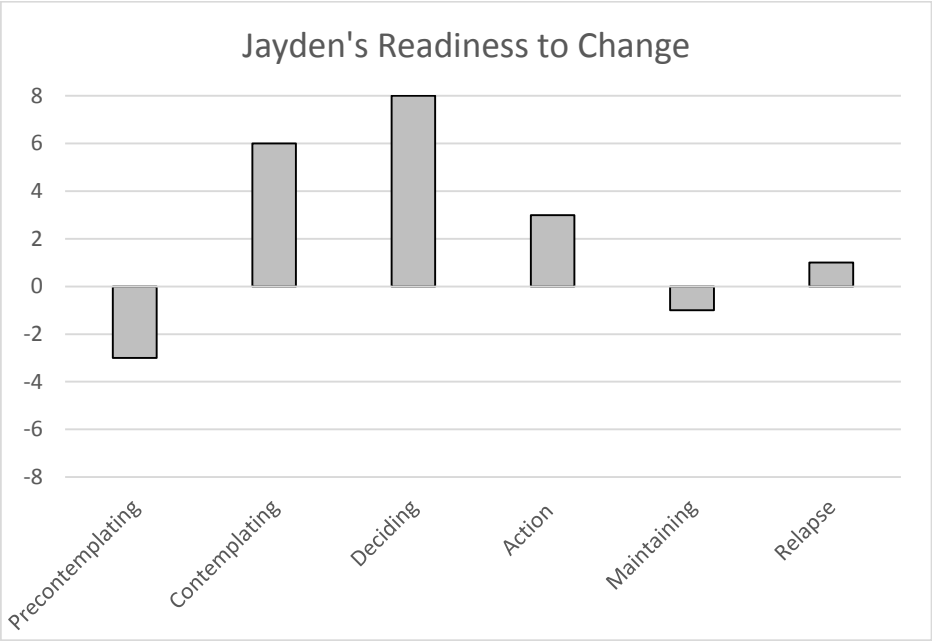
Table 3: O'Connell's (2005) comparison of Prochaska and Diclemente's (1982) stages of behaviour change and de Shazer's (1988) types of client.

	Stage of Behaviour Change	**'Type of client' (de Shazer, 1988)**
1.	Pre-contemplation	Reluctant 'visitors' (the client is referred by someone else and has not requested support or considered a need to change)
2.	Contemplation	The 'complainant' (client) identifies a goal, but shows ambivalence
3.	Preparation/determination	The 'complainant' or 'customer' may have begun setting clear goals for change, or is ready to discuss ideas
4.	Action	The 'customer' is ready to commit to action for behaviour change
5.	Maintenance	The 'customer' discusses maintenance strategies and the client begins to experience some success in problem-free behaviour. This stage also acknowledges the possibility of relapse, in which case the therapist focuses on framing this in an empowering way and focuses on the client's resources and how they prevented getting even worse.

I chose to conduct an initial assessment of Jayden's readiness to change, using the Sheffield Motivational Interviewing card-sort assessment activity (McNamara, 2009). This task requires the young person to identify how far they agree or disagree (on a scale of -4 to +4) with twelve statements, based on typical comments of young people at each stage of change. The total for each stage is calculated to determine which stage characterises the young person. This activity revealed that Jayden seemed to be between the 'contemplating' and 'deciding' stages (Figure 1). In de Shazer's (1988) terms, Jayden seemed to be a 'customer' and seemed ready to discuss his preferred future and strategies to achieve his goals.

Psychological 'formulation' has received increasing interest over recent years and refers to "draw[ing] upon psychological theory in order to create a working hypothesis or 'best guess' about the reasons for a client's difficulties" (Johnstone and Dallos, 2014a, p. xx). Even keen advocates of formulation, however, have questioned whether it is always necessary (Johnstone and Dallos, 2014b), and acknowledge that some therapeutic approaches reject the use of formulation (Johnstone, 2014). Solution-focused therapists argue that it is not necessary to identify or understand the causes of a problem in order to achieve satisfactory outcomes (Beaver, 2011). The approach challenges the positivist use of diagnostic labels and powerful formulations offered by the therapist, instead arguing that language can reframe a situation, shifting the power to the client's strengths and resources (O'Connell, 2003).

Figure 1: Assessment of Jayden's Readiness to Change, using the Sheffield Motivational Interviewing card-sort assessment activity (McNamara, 2009)



I chose, therefore, not to explore Jayden's case history or attempt to explain the 'problems', as is often omitted by solution-focused therapists (O'Connell, 2005). Instead, I embraced the solution-focused principles of identifying his current resources and future hopes (Iveson, 2002). Eliciting these could be considered part of the assessment process, albeit inseparable from the intervention itself (O'Connell, 2005).

3.2 Aim of Intervention

Rejecting the identification of problems, O'Connell (2005) emphasises the importance of the 'focal issue' in SFBT, which should be co-constructed between therapist and client. In this casework, 'the client' refers both to the school staff who made the referral, and to the student, Jayden. I considered both parties to be important stakeholders in this casework, and sought to identify all views on the key issue(s) for change, as recommended by Beaver (2011) and George et al (1999). Initially, consultation with school staff (including the SENCo and two members of pastoral staff) established their aims:

increasing Jayden's on-task behaviour in lessons, lowering the frequency of low-level disruptive behaviours and the intensity of his 'over-excited' behaviours. Subsequently, Jayden identified that he wanted to focus on: being on time to school and to lessons, getting his work done in lessons, asking for help, and being more mature and independent. Jayden and I used scaling to make these goals more specific and realistic, as presented in Figure 2 and described in Section 3.5. These separately ascertained viewpoints revealed similar and complementary aims. If a large discrepancy were identified in future casework, a joint meeting with school staff and the student may serve to negotiate agreed goals for change (Redpath and Harker, 1999).

3.3 Ethical Considerations

In Table 4 below, I have outlined the key ethical principles set out by the BACP's (British Association for Counselling and Psychotherapy) 'Ethical Framework for Good Practice in Counselling and Psychotherapy' (BACP, 2013) and how I have sought to address them in the current case.

Table 4: Description of BACP (2013) principles for ethical practice and application to this case study.

Ethical Principle	Description	Steps Taken to Follow Ethical Principle
Being trustworthy	'Honouring the trust placed in the practitioner (also referred to as fidelity)'. This includes: • Acting in accordance with trust placed in therapist • Ensuring that client expectations are reasonable and can be met • Honouring agreements and promises • Treating confidentiality as an obligation from the client's trust • Restrict disclosure of confidential information, especially if it does not add further purpose to do so	• The SFBT approach, through its use of scaling and setting 'one small step' for improvement, is well-suited to setting realistic expectations. Jayden's expectations were clearly set out using scaling and detailed descriptions of small, concrete behavioural changes. • I followed all agreed actions, following therapeutic sessions, including giving feedback to staff via email from sessions and writing a letter to Jayden at the end of therapy. • The extent of confidentiality offered was agreed with Jayden at the outset. We agreed that a transparent approach to sharing his goals and progress with school staff would be useful. He agreed to share this information, unless he specifically stated that any aspect should remain 'private'. The main exception to confidentiality is safeguarding (Ratner, 2003), so I explained that if Jayden told me something that concerned me about his or others' safety or well-being, then I might have to share even 'private' information.
Autonomy	'Respect for the client's right to be self-governing'. This includes: • Giving accurate information about therapeutic approaches • Seeking freely given and informed consent • Protect privacy • Protect confidentiality	• Through negotiating the *client's* goals and aims for therapy, SFBT lends itself to be client-led. When I offered SFBT to Jayden, I clearly explained that we would work together by talking about how to improve things at school, based on agreeing what *he* wanted to work on. • I made it clear to Jayden that he did not have to work with me and explained what would be involved. I sought verbal consent from him at the start of the therapeutic intervention. (Parental consent was also sought in advance of EP involvement). • To protect privacy and confidentiality, whilst protecting my own safety, our sessions were conducted in a small room 1:1 with the door open.

Beneficence	'A commitment to promoting the client's well-being'. This includes: • Working within one's limits of competence • Systematic monitoring of practice and outcomes to ensure the client's best interests are achieved • Use of research and systematic reflection to inform practice • Regular and on-going supervision to enhance service quality	• Despite my Trainee EP status, I took additional steps to ensure competent practice, including in-depth reading about SFBT principles, techniques and its evidence-base, as well as engaging in therapeutic supervision. • Supervision allowed space to reflect on the casework and how research/theory informed my practice (including detailed discussions about the Stages of Change: Prochaska and Diclemente, 1982) • Session-by-session scaling (as promoted by the SFBT approach) enabled monitoring of progress and outcomes.
Non-maleficence	'A commitment to avoiding harm to the client'. This includes: • Avoiding client exploitation • Avoiding incompetence or malpractice • Ensuring the therapist is fit to practice (including not providing services when unfit to do so, including illness, personal circumstances or intoxication)	• I have sought to avoid incompetence and malpractice, though extensive reading about the approach and critical reflection during supervision. • I have always been mindful of the University of Birmingham's 'Fitness to Practice' guidelines and sought to practice safely in relation to my own health and circumstances.

Justice	'The fair and impartial treatment of all clients and the provision of adequate services'. This includes: • Being just and fair to clients, and respecting their human rights • Justice in the distribution of services and impartiality of provision of services and allocation of services between clients • Fair provision of services, which are accessible and appropriate to clients' needs • Committing to equality of opportunity and avoiding discrimination	• School EP planning meetings serve as a mechanism through which to ensure that pupils have equal access to services, and that services offered are fairly allocated in relation. • Jayden was referred by his school and highlighted as a priority case for therapeutic intervention, in relation to concerns about his behaviour. It was agreed that staff consultation and 3-6 individual sessions of SFBT were proportionate to the staff concerns and fair in relation to others students' needs.
Self-respect	'Fostering the practitioner's self-knowledge and care for self'. This includes: • Applying the above principles as entitlements to therapist too • Using supervision for professional support and development	• Through supervision, I have sought support and development of my professional skills and competencies. • In addition to this, I have drawn upon my own social support networks, including peer supervision with fellow Trainee EPs.

3.4 Working Systemically

I now reflect upon the systemic working, as discussed in Section 2.3. Firstly, before the initial session with Jayden, I conducted a solution-focused consultation[2] with school staff (including the SENCo and two members of pastoral staff), by applying the solution-focused principles, as advocated by Redpath and Harker (1999). This served to clarify aims for school staff and to integrate these alongside Jayden's aims. Solution-focused questioning also led staff to identify strategies and resources to support Jayden. As well as expecting Jayden to change, school staff agreed how they could change the environment and their language to support him (including praise, time for reflection, visual prompt cards, and verbal prompts to support Jayden to make good choices).

Next, I sought to apply the SFBT principles about getting clients to 'notice' improvements (de Shazer, 1985; George et al, 1999), not only by giving Jayden observational tasks, but also feeding back to school staff (via email, Appendix 1), asking them to recognise and reward changes. The SENCO commented that this was helpful to circulate to all staff in the secondary school context, where communicating verbal feedback to a large stakeholder group can be challenging. In addition, as the link (Trainee) EP for the school, I was able to have regular, informal discussions with staff, during school visits. Inkeeping with Ratner's (2003) argument for the advantages of maintaining close contact with school staff, I found this useful to hear updates about Jayden's progress.

In Session Four, Jayden self-evaluated the achievement of his goals and we agreed to end therapy. I wrote him a letter to summarise our work and reinforce his maintenance strategies (Appendix 2). The literature suggests that therapeutic letter writing can have positive effects in supporting the client to make changes (for example Oliver et al, 2007). With Jayden's consent, I copied the letter to school

[2] The term 'consultation' is a confusing term and often connotes a medical model of professionals giving advice. However, I have used the term, as suggested by Leadbetter (2006), to refer to a process consultation, seeking to empower the problem owner (school staff in this instance) and seek solutions. This approach is recommended by Fox (2009).

staff to further reinforce our consultative work, as supported by Bozic (2004), who reported that teachers (n=10) also strongly value this kind of letter, attributing up to fifty percent of the positive impact of EP involvement to it.

Lastly, seven weeks after the end of therapy, I organised a joint consultation review with school staff and Jayden. This proved an excellent opportunity for Jayden to hear positive feedback from staff about what was going well and the changes he had made. This seemed to be empowering for Jayden: he smiled throughout and noticeably lifted his posture with pride.

3.5 Description of SFBT Intervention and Reflections on Fidelity

I now describe and reflect upon my professional decision-making at each stage of the SFBT intervention with Jayden. Firstly though, I offer a critical commentary on the construct of fidelity, as this underpinned my approach to applying SFBT techniques. 'Fidelity' refers to the level of integrity to the approach and adherence to the original protocol for treatment (Lehman and Patton, 2012). It is considered important for several reasons: to develop replicability of the model; and to determine whether outcomes are attributable to the SFBT model or poor implementation (Lehman and Patton, 2012). Furthermore, high fidelity is considered by many to be useful for improving research quality and methodological rigour (Gingerich et al, 2012; Corcoran, 2012; Lehman and Patton, 2012).

One way to assess fidelity is by using standardised measures, such as Lehman and Patton's (2012) 13-item fidelity instrument, which was created from criteria described throughout the SFBT literature. The tool is limited by its intended use in the sixth session of therapy. This is, for some, beyond the scope of so-called 'brief' therapy: Iveson (2002) suggests an average of five sessions. In addition, due to focusing on the sixth session, the tool omits cornerstone techniques used in earlier sessions, such as the miracle question.

Fidelity can also be assessed against descriptions of SFBT characteristics. De Shazer and Berg (1997) described these as: the first session includes the miracle question; scaling (0-10 or 1-10) is used at least once; and the therapist takes a break and afterwards gives compliments and (usually) a homework task. These criteria were selected for research purposes at the time, although the authors acknowledge that in practice there is no rigid protocol and suggest that interventions can still be considered SFBT without all these features (de Shazer and Berg, 1997). This highlights a further purpose of assessing fidelity: to establish whether strict adherence to the model is required or whether flexible implementation is still effective (Lehman and Patton, 2012). Preliminary evidence suggests that some degree of flexibility may still allow for positive outcomes: Wilson (2005) openly acknowledged some deviations from SFBT, but still found significant positive changes. Alternatively, fidelity can be evaluated through transparency in reporting intervention details, as suggested by Gingerich and Peterson (2013): this is my aim in this Professional Practice Report. This seems more appropriate to the origins and development of SFBT and can contribute to knowledge about 'what works' in SFBT.

From the literature reviewed, I ascertained that SFBT is an approach in which the therapist skilfully applies a set of techniques, as outlined in Table 1 and Table 5. I adopted O'Connell's approach to SFBT, which suggests that the solution-focused model should be adapted to suit the client: not the other way around (O'Connell, 2005). This implies that the SFBT model is flexible, not mechanistic, and should be used as a guide; it would not appropriately be scripted or manualised (O'Connell, 2005). The selection and sequencing of techniques should, therefore, be carefully selected to suit the client (O'Connell, 2003). My application of SFBT principles and techniques with Jayden is described and reflected upon session-by-session in Table 5.

Figure 2: Session-by-session scaling used with Jayden.



Table 5: A session-by-session description of my application of SFBT principles and techniques with Jayden.

Session	Description of Activities	Reflections
Session 1	1. Rapport building 2. Assessment of readiness to change using card sort activity (McNamara, 2009) 3. Establishing best hopes 4. Miracle question 5. Scaling 0-10 6. Assessment of motivation and confidence	7. After establishing a good rapport and assessing Jayden to be between the 'contemplating' and 'deciding' stages of change, it seemed appropriate to begin to explore his best hopes, during this initial session. 8. The miracle question was a useful tool to facilitate in-depth discussion about the preferred future, including detailed exploration of behavioural changes and relationship questions (Who will notice? What will they notice?) 9. Scaling was used to establish Jayden's assessment of the current situation and realistic goals (Figure 2). In order to make it more appealing, as recommended by Ratner (2003), I personalised the scale to Jayden's interests by drawing a football at point 3.5 to represent the current situation, and a goal post at point 8 to represent the goal. 10. Assessing motivation and confidence is also often recommended as a useful technique in the early stages of SFBT (George et al, 1999; O'Connell, 2005), in order to shape future sessions. During session one, I asked Jayden to rate himself on a scale out of ten (where ten is high), as to how confident he felt that he could achieve his goals (he rated himself 9/10) and how motivated he was to do so (he rated himself 10/10). The validity of these high scores could be questioned, in relation to the potential influence of demand characteristics and Jayden wanting to impress me. However, I don't think this is necessarily a limitation. Research demonstrates links between hopefulness, the therapeutic relationship and intervention outcomes (Rees, 2005) and therefore, Jayden's apparent commitment to achieving his goals may have been strongly influenced by our good rapport and therapeutic relationship, but this may result in positive intervention outcomes.
Session 2	• Debriefing following an exclusion (not planned as part of SFBT!) • Review of scaling	• During the time since session 1, Jayden was involved in an incident resulting in an exclusion. He appeared to need to debrief and reflect upon the session before he was ready to return to discussing the initial goals set. By demonstrating that I wanted to see things from his perspective and help him learn from his mistakes, this helped to further strengthen our rapport and therapeutic alliance. The conversation became effortlessly solution-focused, asking 'How can we make this situation better?'

	• Focus on strengths and resources	• I then asked what improvements he'd made that week, using his scale to structure the discussion, and asking for specific examples of when he had noticed improvements. • I used curiosity to inquire about his strengths and resources, asking 'How did you do it?' and 'What made you decide to do that?' • Although he'd noticed some positive changes, Jayden only wanted to move himself from 3.5 to 4, due to his exclusion.
Session 3	• Discussion of improvements using scaling • Identification of helpful resources • Further reinforcement of cognitive changes ('What made you choose to do that?' and 'How did you decide?')	• I began the session by asking 'what's gone well this week?' Jayden was smiling and told me that his 'report card' has been helpful and he was proud of being rated 'A's and 'B's in most lessons. • However, he felt the 'report card' held negative associations as it is only used in school following an exclusion. We considered the helpful element of monitoring his behaviour and co-constructed a 'reward card' to achieve the same purpose. Jayden had ownership of this and felt proud of this idea, suggesting that he thought other students may benefit from this; in fact, the 'reward card' has now been adopted by the school.
Session 4	• Review of scaling • Further reinforcement of strengths and resources • Agreed to end 1:1 sessions • Agreed to write a letter to Jayden summarising the work (with his consent to copy in staff) • Agreed to review with staff in approximately half a term's time.	• Jayden self-evaluated that he had achieved all the agreed behavioural criteria to rate himself 8 out of 10: his initial goal. • We explored how he had managed to progress from 3.5 to 8 and how he planned to maintain this change. • We agreed to end therapy, as Jayden had clearly achieved his goals and felt positive to continue these improvements. This was based on the principle that SFBT should be 'brief' and that therapy should end as soon clients are satisfied that their goal has been achieved and that they are able to maintain positive changes (de Shazer, 1991). • In order to support maintenance of these changes, I asked Jayden if there was anything that would help him to keep up these improvements and he identified cognitive strategies, such as coping self-talk (e.g. "telling myself I can do it"), as well as staff noticing his positive changes and continuing to reward him with 'vevos'. These ideas were fed back to staff via a copy of the letter to Jayden.

4. Outcomes and Evaluation

For EPs, the importance of demonstrating the impact of involvement is widely recognised (Beaver, 2011), but this raises questions about what to evaluate and how (Gillapsy and Murphy, 2012). In evaluating SFBT, many authors promote the use of standardised outcome measures, arguing that this improves methodological rigour (e.g. Corcoran, 2012). However, the core philosophy of SFBT centres on the co-construction of the negotiated goals of the client. The ultimate aim of therapy is to create a significant change or difference in clients' lives (de Shazer, 1991) and I fully agree with Gillapsy and Murphy (2012, p. 73) that, in SFBT, "the client is the ultimate authority on the usefulness of services".

Furthermore, the aim of SFBT is often to achieve small, concrete changes, which may not be recognised by standardised measures, which are unlikely to demonstrate discriminatory power between pre- and post- intervention measures. I consider that standardised measures are not generally well-suited for SFBT and I deemed them inappropriate for this case study. Instead, client scaling, which is one of the cornerstone techniques of SFBT (Iveson, 2002; O'Connell, 2003; George et al, 1999), can be used to assess clients' perceptions of goal attainment (Gillapsy and Murphy, 2012). This client-based scaling privileges the client's voice (Gillapsy and Murphy, 2012) and their assessment of progress in relation to their specific, agreed goals.

The hand-drawn scaling developed with Jayden and our week-by-week contemporaneous annotations are shown in Figure 2. This illustrates how, over the course of the SFBT intervention, Jayden rated himself as progressing from 3.5 to 8 on his scale (Figure 2), thus achieving the goal he set in the initial session. At follow-up, seven weeks after the final session, during the consultation review meeting, Jayden agreed to share his scaling (Figure 2) with staff. At that time, he rated himself as remaining on 8 on his scale (the original goal) and had, therefore, managed to maintain positive changes since ending

therapy. Furthermore, qualitative feedback was sought from school staff, who reported that Jayden was “loads better” and described him as more mature and sensible, particularly in group work. They also noted reduced shouting out and pushing other students, as well as Jayden being able to wait more calmly (e.g. in the dinner hall). Staff commented that, academically, they felt like Jayden was learning more and that he seemed proud of his work, as well as noticing more articulate responses to class discussions and a reduced need for adult prompts.

5. Conclusion and Reflections

In this Professional Practice Report, I have critically considered some important issues for EPs engaging in therapeutic work in schools. I have noted pressures to implement ‘evidence-based practice’, whilst reflecting on the valuable role of practice-based evidence in SFBT. I have also highlighted the importance of transparency in reporting interventions, in order to assess fidelity and develop research into ‘what works’ in SFBT. Through this casework, I have considered the role of assessment and formulation in SFBT and concluded that assessing readiness to change is useful to tailor the intervention to the individual, but that formulation is not necessary, as solutions can be sought without identifying the causes of problems. In addition, I have considered ways of evaluating the outcomes of therapeutic work and concluded that, in SFBT, client scaling is a practical and empowering method for evaluation.

Finally, this casework and associated reading have enabled me to shape my professional identity as an EP, in realising my affiliation with the values and philosophy of solution-focused approaches. As noted by Stobie et al (2005, p. 25), solution-focused interventions are attractive to EPs “not least because of both the ‘tools’ involved and the strong emphasis on ‘change’ rather than a search for the roots of

problems." I have found the process and outcomes of this casework to be highly rewarding. In the final follow-up meeting, I noticed that staff, Jayden and I were all extremely positive in giving feedback about his successes, perhaps owing to the 'ripple effect' described by Williams (2000). Furthermore, by applying recommendations from the literature about intervening at multiple levels of 'the system', I have learned that systemic working can maximise positive outcomes for all stakeholders. I conclude that in order to intervene most successfully using SFBT, a systemic approach is needed.

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PPR2 APPENDIX 1: CONTENT OF EMAIL FEEDING BACK TO SCHOOL STAFF

Hi [all]

Here's a quick bit of feedback from my session with Jayden today. Shall has offered to take a lead on this work, but it is important that these strategies are shared with all staff, in order to maximise opportunities for Jayden's success.

Systemic strategies to support Jayden:

Noticing when he's on time (or early!) to lessons/form time

- Noticing him walk quickly down the corridors
- Supporting and empowering him to ask for help if needed (Try using card system – see attached)
- Noticing him listening
- Noticing his 'mature' behaviour

Jayden is highly motivated by praise and 'vevos' –these can be used to reward desired behaviours.

I look forward to hearing how things are going next week

Best wishes

Fiona

PPR2 APPENDIX 2: LETTER TO FEEDBACK TO JAYDEN (AND SCHOOL STAFF)

10th December 2014

Dear Jayden,

I am writing to feedback about the work we did together over the last few weeks.

We used a 'solution-focused' approach to think about how you would like things to be better. You wanted to improve:

- Being more mature and sensible (walking sensibly around school, getting to lessons on time and getting your work done)
- Being more independent (making your own bed and breakfast)
- Asking for help when you need it
- Arriving to school on time

We drew a scale to talk about your progress (see attached). You started rating yourself at 3.5 out of 10, and set a target of 8 out of 10. By the end of our work together, you showed excellent progress on these targets. I was particularly impressed with how you decided to make these positive changes and chose to carry them through. You were good at reflecting on what had helped you to achieve these things. You said that you'd told yourself to 'just do it' (*psychologists call this positive self-talk*). When we last met, you rated yourself 8 out of 10.

Adults in school told me that they are impressed with the changes you've made. They've noticed that you seem to be more mature and that you're getting a lot more 'vevos'. I have shared our work with the adults in school and supported them to help you, including:

- Noticing when you:
    - are early to school
    - are sensible in the corridors
    - ask for help in lessons
    - get your work done or try hard to do so
- Giving you more vevos for doing these things well

- Giving you a ‘reward card’ to score each lesson, aiming for As and Bs (like a report card, but more positive)

Because you said it would be OK, I’ve sent a copy of this letter to your teachers and parents. We agreed to meet in February to review the situation and check that things are still going well. Remember – if you would like more help with making good choices, you can always talk to your parents, adults in school, or ask to see me again.

I have enjoyed working with you. It has been a pleasure to see you maturing and making some positive choices. I look forward to hearing how you are getting on.

Best wishes



Fiona Cane
Trainee Educational Psychologist

Copies: 1. School staff
2. Parents
3. Psychology Service pupil file

Enclosed: Scales - showing targets and outcomes of solution-focused therapeutic work

CHAPTER FOUR

PROFESSIONAL PRACTICE REPORT THREE

PROMOTING SCHOOL STAFF WELL-BEING USING THE TEN-ELEMENT MAP:
AN ACTION RESEARCH PROJECT USING THE RADIO MODEL (PART 1)

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PPR3: PROMOTING SCHOOL STAFF WELL-BEING USING THE TEN-ELEMENT MAP: AN ACTION RESEARCH PROJECT USING THE RADIO MODEL (PART 1)

Abstract

This paper (part one of two) outlines the initial stages of a collaborative action research project seeking to promote staff well-being in a West Midlands special school. The rationale for the project is twofold: firstly, in my role of a school-based Trainee Educational Psychologist (EP), the school requested my support to improve staff well-being; and secondly, the literature calls for action research in this area. The paper adopts a salutogenic model of mental health and well-being, which considers both increasing health-promoting factors and reducing risk factors. Reflecting this philosophy, the 'ten-element map' (MacDonald and O'Hara, 1998) was applied as a framework to guide data collection, analysis and action planning. The map's contemporary relevance is discussed, with positive conclusions. The RADIO model (Research and Development in Organisations; Timmins et al, 2003) was employed as an overarching framework to structure the action research. This paper highlights the valuable contribution that EPs can make to organisational development work in schools and emphasises the importance of the initial entering and contracting phases in securing a strong foundation for a successful project.

1. Introduction

1.1 Overview of the project

I have used the three-phase RADIO model (Research and Development in Organisations, Timmins et al, 2003; Figure 1) to structure this project and the two resultant reports. In this first Professional Practice Report, I describe the early stages of the action research project in a special school, which aims to improve staff well-being. I discuss the processes involved for Educational Psychologists ('EPs'

hereafter) in entering and contracting with school stakeholders ('clarifying concerns': RADIO Phase One) and the methodological decision-making regarding diagnosis of the current functioning of the school ('research methods mode': RADIO Phase Two). In the second Professional Practice Report, I reflect upon the processes throughout the action planning, implementation and evaluation stages ('organisational change mode': RADIO Phase Three), describing how the diagnostic information was processed with stakeholders to inform the collaborative development and implementation of an action plan, and to evaluate organisational change. Across both papers, I offer a critical appraisal of the RADIO model and reflect upon the role of EPs as action researchers and facilitators of organisational change.

RADIO phases	RADIO stages	Typical activities
Clarifying concerns	1. Awareness of need	School/EPS/LEA request or EPS suggestion
	2. Invitation to act	Contracting EP role in organisational development
	3. Clarifying organisational and cultural issues	Exploring opportunities and threats relating to initiative
	4. Identifying stakeholders	Agreeing processes for collaborating with stakeholders for feedback and discussion, e.g. coordinating group and initiative co-ordinator
	5. Agreeing the focus of concern	Identifying research aims and purposes.
Research methods mode	6. Negotiating the framework for data gathering	Issues and decisions regarding methodology, methods, resources and timescales
	7. Gathering information	Using agreed methods
	8. Processing information with stakeholders	Sharing findings with stakeholders
	9. Agreeing areas for future action	Discussing findings in relation to organisation's needs and identifying areas action for
Organisational change mode	10. Action planning	Stakeholder-led planning process
	11. Implementation /action	Stakeholders facilitating change within organisation
	12. Evaluating action	Stakeholders reviewing effectiveness of action and possibly requesting further EP involvement

Figure 1: The RADIO (Research and Development in Organisations) model, taken from Timmins et al (2006, p. 307).

1.2 Organisational Development and Action Research

Organisational development ('OD' hereafter) is the process of applying psychology to support organisations to "build the capacity to change and to achieve greater effectiveness" (Cummings and Worley, 2005, p. 1). It is a planned change effort, involving the whole organisational system (Beckhard, 2006), with the aim of improving 'organisational effectiveness', including financial performance or improved quality of work life (Cummings and Worley, 2005).

Organisational development draws many parallels with action research. Some consider them synonymous, as both seek to combine professional action with scientific enquiry (Cummings and Worley, 2005). The term 'action research', coined by Lewin in 1946 refers to the combination of aiming to improve practice (action) and creating new knowledge (research; Burnes, 2006). Definitions of these terms are largely undisputed, but there is disagreement about the requisite balance of emphasis (McNiff and Whitehead, 2011). Practitioner-researchers tend to focus more heavily on the *action*, including participation and empowerment, whilst organisational action researchers tend to focus more on the *research* and data-driven decision-making (Dickens and Watkins, 2006). It is commonly agreed that the purpose of action research is to improve practice or to develop an organisation (Cummings and Worley, 2005; Koshy, 2010; McNiff and Whitehead; Reason and Bradbury, 2006; Thomas, 2013).

Most action research models are derived from Lewin's three stage model of planned change (Burnes, 2006). The first stage, 'unfreezing', suggests that natural equilibrium needs to be de-stabilised (unfrozen) in order to gather information (research) to demonstrate the discrepancy between actual and desired states (Burnes, 2006; Cummings and Worley, 2005). The 'movement' phase involves implementing change interventions (Cummings and Worley, 2005) and 'refreezing' describes re-stabilising the organisation at a new state of equilibrium (Cummings and Worley, 2005). Most action research models are based on iterative cycles of diagnosis, planning, action and evaluation (Freedman,

2006). This principle originates in critical theory, which highlights the importance of understanding a situation in order to change it (McNiff and Whitehead, 2011).

1.3 Research and Development in Organisations (RADIO) model

Action research frameworks have been developed to suit various professional fields (Cummings and Worley, 2005). The Research and Development in Organisations model was originally developed (although not published) by tutors on the Educational Psychology training course at the University of Birmingham (Knight and Timmins, 1995, cited by Timmins, Shepard and Kelly, 2003). The model (Figure 1) has twelve stages split into three phases: (i) Phase One: clarifying concerns (i.e. entering and contracting), (ii) Phase Two: research methods mode (i.e. diagnosing), and (iii) Phase Three: organisational change mode (i.e. planning, implementing and evaluating change). Although the RADIO model implies a sequential approach, there is flexibility to move between and revisit various stages (Timmins et al, 2003).

A literature search, using the 'ProQuest Social Sciences' database, returned only three published papers that referred to the RADIO model, but authors' evaluations were positive. The model is considered to provide a clear and useful framework for action research (Ashton, 2009; Timmins et al, 2003) and allows for relatively tight timescales (Timmins et al, 2006). The model's collaborative orientation and co-construction of processes are reported to improve stakeholder engagement and reduce the perceived 'threats' of change (Timmins et al, 2003). Furthermore, it allows flexibility in negotiating the methods for data collection and analysis (Ashton, 2009) and is reported to show potential for negotiating school improvement (Timmins et al, 2003). The RADIO model was therefore operationalised to structure the current project.

2. Phase 1: Clarifying Concerns

The 'clarifying concerns' phase is akin to 'entering and contracting' (Cummings and Worley, 2005; Gallant and Rios, 2006). This initial phase aims to identify the organisation's needs and establish a collaborative partnership between the facilitator and stakeholders (Cummings and Worley, 2005; Dalin, 1993; Timmins et al, 2003). The RADIO model's social constructionist orientation is particularly apparent: the focus of research is carefully negotiated to develop shared meanings (Timmins et al, 2003). This is echoed by Reason and Bradbury (2006, p. 7), who argue that action research is inherently participatory and therefore "the 'reality' we experience is a co-creation". Activities in this phase set the parameters for the subsequent stages (Cummings and Worley, 2005) and are considered to be "the keystone for success of the entire OD process" (Gallant and Rios, 2006, p. 177).

2.1 Stage 1: Awareness of need

The need for this project is twofold: (i) a practical need to improve staff well-being, identified by school professionals; and (ii) a clear argument supporting the value of action research to promote staff well-being in schools, established through a literature review.

2.1.1 *Need: Identified by the school*

OD projects are usually driven by the "inner realization that change is necessary" (Burnes, 2006, p. 140). This 'felt need', usually at the strategic or managerial level in an organisation (Beckhard, 2006), may arise from external, environmental triggers for change or internal triggers from within the organisation (Senior and Swailes, 2010). Although some external factors have played a part, namely the growing political and empirical interest in promoting staff well-being in schools (discussed in

Section 2.1.2), the 'felt need' for the current project was primarily triggered by factors internal to the focus school, where improving 'staff well-being' was identified as an area for school improvement during a Psychology Service planning meeting with the Headteacher and Deputy Head.

2.1.2 Need: Arising from the literature review

The necessity for a formal literature review in action research remains disputed, reflecting differing positions within the *action* versus *research* debate. The RADIO model itself (Figure 1) omits an overt literature review stage: reference to literature could, instead, run throughout the report (McNiff and Whitehead, 2011). I propose that the literature review is an important aspect of the research and has been useful in clarifying the issue and identifying an appropriate 'diagnostic' model for organisational change. As recommended by Koshy (2010), I will briefly outline relevant policy to set the context for this project. I will describe definitions of well-being and outline relevant theoretical models and empirical research, which provide a rationale for *promoting* staff well-being in schools.

The term 'well-being' is difficult to define, because of its multi-dimensional and subjective nature (Evans, 2011). Dictionary definitions refer to "the state of feeling healthy and happy" (Cambridge Dictionaries Online, 2014), and "a good or satisfactory condition of existence... characterized by health, happiness, and prosperity; welfare" (Dictonary.com, 2014). The Office for National Statistics well-being debate revealed common themes relating to well-being and the conditions in which it is best able to flourish: physical health, adequate income/wealth, the environment, social/community connections, work-life balance, and participation in cultural/creative/outdoor activities (Evans, 2011). The terms 'well-being' and 'mental health' are often used synonymously: the World Health Organisation (2013) defines 'mental health' as "a state of well-being". I will predominantly use the term 'well-being' as identified by the school, although I may also refer to 'mental health', as reflected in the literature.

National political interest in promoting mental health and well-being is growing. Mental health was identified as a key element of public health in the white paper, 'Healthy Lives, Healthy People' (DOH, 2010). Subsequently, the government strategy 'No Health without Mental Health' (DOH, 2011), relevant to people of all ages, established the equal status of physical and mental health and reported that at least one in four people will experience a mental health problem during their lifetime (DoH, 2011). The paper advocates the principle that "mental health is everyone's business" (DOH, 2011, p. 5), which has obvious implications for schools as communities of children, young people and their families, employers, employees and educators.

In the school context, recent mental health initiatives have focused on the well-being of children and young people (Social and Emotional Aspects of Learning, DfES, 2005; Targeted Mental Health in Schools project, DCSF, 2008, 2010), although there is an increasing recognition of the parallel importance of *staff* well-being in schools. Roffey (2012) suggests that staff and student well-being may be 'two sides of the same coin', with findings that well-being interventions for both teachers and pupils can have synchronous and complementary effects. Further research emphasises the importance of meeting staff members' emotional well-being needs, in order to support pupils' emotional well-being needs (Partridge, 2012). Staff well-being may also influence student outcomes: in a sample of 24,100 primary and secondary school staff, Briner and Dewberry (2007) concluded that 8% of the variance in SATs (Standard Assessment Tests) was accounted for by teacher well-being.

Evidence suggests that staff well-being in schools is problematic. The NASUWT (National Association of Schoolmasters Union of Women Teachers; 2010) claim that the majority of teachers reported always or often feeling tired (69%), stressed (61%) or anxious about their job (58%). Research has typically focused on *why* this may be the case. Commonly reported stressors include: managing excessive workload, lack of professional support, poor peer relationships, lack of co-operation, interpersonal

conflict, pupil behaviour, workplace changes, poorly defined role boundaries and lack of control (NASUWT, no date). Another study reported that pupil behaviour, workload and emotional exhaustion were the most common sources of teacher stress (Brichino et al, 2009). Support staff may also encounter challenges to their well-being. This is attributed to the emotional impact of managing others' emotional needs and may be further compounded by time pressures, lack of training or preparation, anxiety and rumination about their work, and lack of processing time to offload and reflect (Partridge, 2012). Evidence suggests the particular vulnerability of staff working with pupils with special educational needs, as a result of the additional emotional demands involved in dealing with challenging behaviour (Lambrecht and Maes, 2012). This research is particularly relevant to the current study's school context: a special school for primary and secondary pupils with severe learning difficulties and autism, many of whom express challenging behaviour.

Whilst this research focuses on identifying stressors (NASUWT, no date; Brichino et al, 2009; Lambrecht and Maes, 2012), research into what actively promotes and enhances well-being is scarce (Brichino et al, 2009; Roffey, 2012). One study identified factors that promote well-being in schools: emphasising pro-social values, fostering a sense of belonging, feeling included, valued, respected and cared for, creating a safe learning environment, positive collegial relationships, positive teacher-student relationships, positive feelings and resilience (Roffey, 2012). Furthermore, in two 'exemplary' schools with good staff well-being despite challenging circumstances, three key elements were identified: nurturing psychological resilience, commitment to learning as adults, and an open, non-judgemental approach (Rumsby, 2007). Another study reported that leadership and quality professional learning are key school characteristics that promote mental health (Rowling, 2009). Interestingly, these factors are all related to school culture and organisational level influences. Evidence suggests that, although some targeted interventions may improve staff well-being, the most effective way to reduce job-related stress is through organisational interventions (Brichino et al, 2009). Despite this, research

demonstrating sustained organisational approaches to promoting well-being rather than targeting individual stress management is still rare (Rumsby, 2007). Brichino et al (2009) recommend that action research to *promote* staff well-being in schools should now be undertaken and evaluated, providing a clear rationale for the current study.

This shift to *promoting* mental health and well-being follows a theoretical re-conceptualisation of mental health from a pathogenic to a salutogenic model. The historical pathogenic view of mental health refers to a dichotomy: humans are mentally healthy until something happens to make them mentally ill (MacDonald, 2006). Antonovsky (1996) uses the metaphor of swimming in a river – 'the stream of life' – to liken being healthy with staying afloat. Traditional medicine has been curative (i.e. helping those already drowning) or preventative (i.e. reducing risk factors associated with drowning), but he asked, "what of health promotion?" (p. 13; i.e. helping people to swim). Antonovsky coined the term 'salutogenesis' in 1979, which re-defined health and illness on a continuum and suggested that good health could be positively promoted (Antonovsky, 1996). He argued that not only should we seek to reduce risk factors, but we should also identify and increase 'salutary factors' (health-promoting factors). This was further developed by Albee and Ryan-Finn (1993), who argued that primary prevention in mental health involves both reducing 'noxious agents' and strengthening coping and resistance to stress. Following a literature review, they proposed a formula to encapsulate this (Figure 2).

$$\text{Mental illness} = \frac{\text{organic factors + stress + exploitation}}{\text{coping skills + self-esteem + social support}}$$

Figure 2: Albee and Ryan-Finn's (1993) formula to describe mental illness

From these six elements, MacDonald and O'Hara (1998) adapted the formula to a more pragmatic conceptualisation of factors that promote and demote mental health (Figure 3).

Mental health	=	Environmental Quality	+	Self-esteem	+	Emotional Processing	+	Self-management skills	+	Social participation
		Environmental deprivation	+	Emotional abuse	+	Emotional negligence	+	Stress	+	Social exclusion

Figure 3: Practical factors that promote and demote mental health (MacDonald and O'Hara, 1998)

From this, they developed a conceptual model: the ten-element map (Figure 4), which comprises five areas from the above formula, which each have a 'promotion' and 'demotion' element and includes three levels: micro (individual), meso (organisational) and macro (societal). Philosophically, the model rejects the essentialist view that mental health is an individual state, instead acknowledging the social, cultural and historical influences on mental health. MacDonald and O'Hara (1998) argue that it is neither effective nor moral to focus solely on individual factors that promote mental health, whilst ignoring social factors that may simultaneously demote it.

Sixteen years after its initial conception, the map's evidence base and contemporary relevance must be questioned. A literature search returned only one peer-reviewed published article citing use of the map. This paper explored the social and emotional experiences of children (n=18) in one primary school at the meso level (Hall, 2010). Two further thesis papers were identified: one action research study used the map to develop whole-school practices to promote children's mental health (Williams, 2013), and another large-scale study used the map as an audit tool to elicit staff (n=361) and pupil (n=219) views across fourteen schools (Baker, 2014). In relation to recent initiatives (namely SEAL, DfES, 2005), Hall (2010) reported that the map is still relevant. In my view, the map has concurrent validity with contemporary definitions and models of mental health in literature and policy documents (Evans, 2011; DoH, 2011), which emphasise the active promotion of good mental health and assume

that salutary factors lead to good physical and mental health, positive relationships and success in education, work and training.

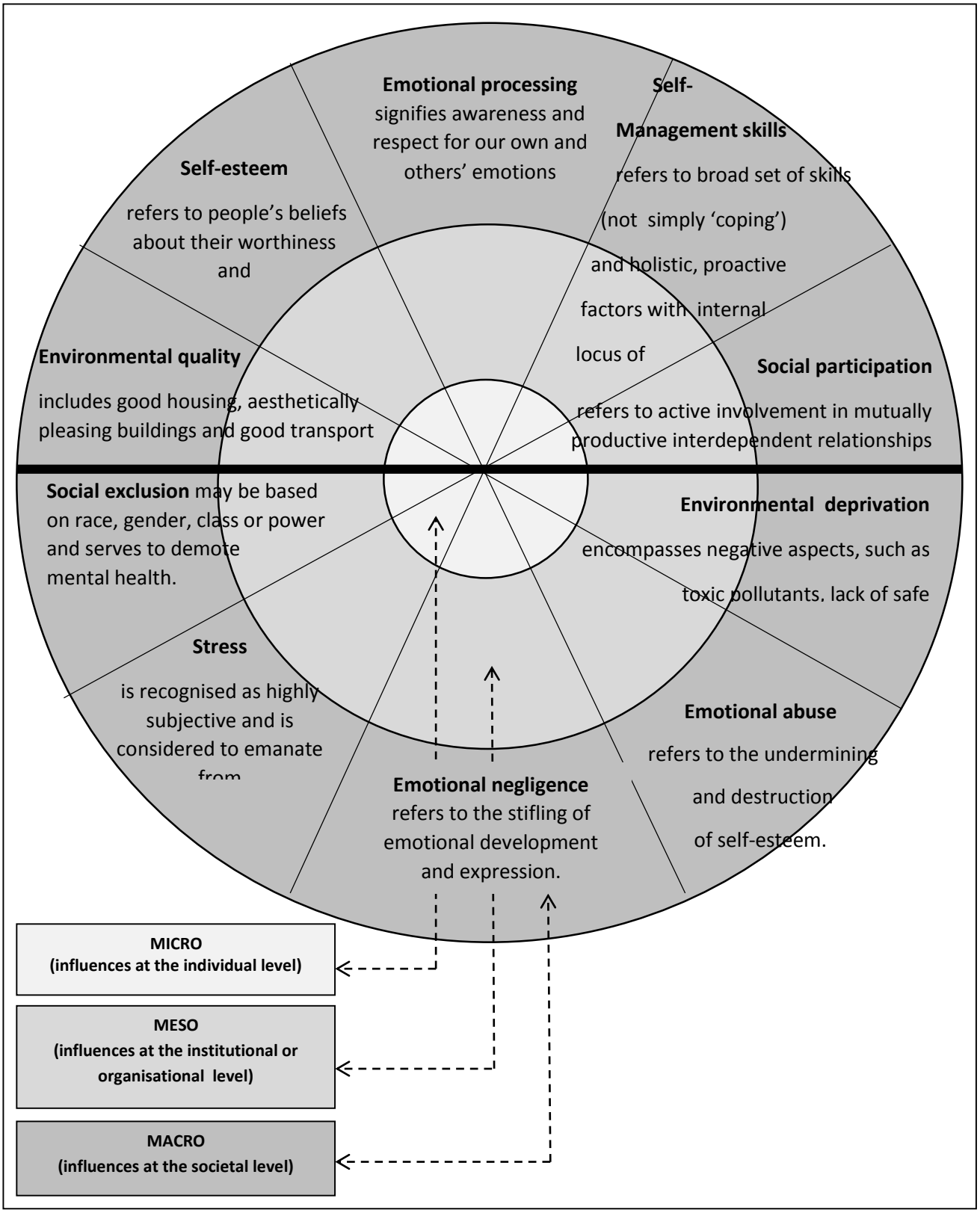


Figure 4: The ten element map of mental health promotion and demotion (MacDonald and O'Hara, 1998)

The map was originally recommended for use as a planning tool, to identify current practice and to plot future activity (MacDonald and O'Hara, 1998). Feedback from recent studies suggests that the ten-element map is a useful framework to structure data collection (Hall, 2010) and conceptualise findings from a bio-ecological perspective (Williams, 2013), as well as for planning action at the organisational level (Baker, 2014; Hall, 2010; Williams, 2013). This lends itself extremely well to the principles of action research.

From this brief literature review, I concluded that the context was ripe for the current action research project to *promote* staff well-being in a special school. The literature calls for more action research on this topic (Brichino et al, 2009) and indicates that the ten-element map may afford a useful framework to guide such research (Baker, 2014; Hall, 2010; Williams, 2013). The National Union of Teachers (NUT, 2011) recommends that Headteachers should work collaboratively with local authority consultants to promote staff well-being and, with their research knowledge and skills, and good connections with schools, EPs are well-placed to collaborate with schools in action research (Roffey, 2012). Furthermore, there is a clear rationale for the potential benefits (to staff and students) of promoting staff well-being, which indicates that this is a valuable and appropriate activity for EPs (Roffey, 2012).

2.2 Stage 2: Invitation to act

After identifying a need for organisational change, leaders often contact an OD practitioner to help address the issue (Cummings and Worley, 2005). The RADIO model's 'invitation to act' involves contracting an EP to engage in school OD work (Timmins et al, 2003). In this project, the 'invitation to act' occurred during a Psychology Service planning meeting with the Headteacher and Deputy Head. After agreeing to be the key stakeholder (see Section 2.4), the Deputy Head and I met to set the more detailed parameters of the OD process (Gallant and Rios, 2006), including establishing mutual

expectations, time and resources, and setting ground rules (Cummings and Worley, 2005). Based on recommendations to establish a clear model for the OD process (Cummings and Worley, 2005), I shared the RADIO model with the Deputy Head, which provided a useful structure to create a shared vision of the project and agree approximate timescales. I also clarified my expectations and gained consent to report the study as part of my doctoral thesis.

2.3 Stage 3: Clarifying organisational and cultural issues

So far, applying the term 'organisational development' to a school project has assumed that schools are organisations. The literature supports this notion: Handy and Aitkin (1986) described seven key defining concepts of schools as organisations: the strategy, structure, system, staff, skills, style and shared values. Schools have their own distinct organisational culture, which Thacker (1994, p. 11) describes as "the guiding beliefs and expectations in the way a school operates, particularly how people relate (or fail to relate) to each other". This description is based on Schein's three levels of culture (Box 1; Schein, 2010), which was originally proposed in 1985 (Huczynski and Buchanan, 2001). Thacker (1994) suggests that 'artefacts' and 'espoused beliefs' are openly manifest (through classrooms, grounds, furnishings, displays, the prospectus, uniform, timetabled events), but that culture, as in Schein's 'basic underlying assumptions' or "the way we do things and relate to each other around here" (Thacker, 1994, p. 11), is harder to surface, because it "resides mostly in the taken-for-granted".

Schein's Three Levels of Culture

1. **Artefacts** *(Difficult to decipher)*
   - Visible and tangible structures and processes
   - Observable behaviour

2. **Espoused Beliefs and Values** *(May or may not be congruent with behaviour/other artefacts)*
   - Ideals, goals, values and aspirations
   - Ideologies
   - Rationalisations

3. **Basic Underlying Assumptions** *(Determines behaviour, perception, thought and feeling)*
   - Unconscious, taken for granted beliefs and values

Box 1: Schein's Three Levels of Culture, from Schein (2010).

Despite the time and effort required to invest in surfacing the culture, this may be highly beneficial. Organisational culture can act as a force for stability (and therefore as an impediment to change) or as a force for change (Thacker, 1994). This is recognised throughout the RADIO model (Timmins et al, 2003) and Stage Three offers an opportunity to explore these potential influences, so establishing the project's feasibility and seeking to identify and address any potential threats to its success. The RADIO model recommends analysing the opportunities and threats posed by the school's culture (Timmins et al, 2003). I used the elements of organisational culture described by Senior and Swailes (2010) to consider potential opportunities and threats through discussions with the Deputy Head and my own reflections (Table 1). From this analysis, I concluded that the influence of this school's culture comprised a predominantly positive force for change, revealing more opportunities for organisational development than threats to its success. This analysis also revealed the powerful influence of school management professionals (including the key stakeholder) on school culture, which will now be discussed.

Table 1: Identified opportunities and threats arising from different elements of organisational culture, taken from Senior and Swailes (2010).

Element of Organisational Culture	Considerations Related to the School	Opportunity or Threat?
Attitudes to criticism	• Key stakeholder (Deputy Head) was very open to constructive criticism from staff. She made this clear during data gathering when asking staff to give their honest ideas and opinions.	Opportunity
Degree of management's openness to new ideas (especially from below)	• Deputy Head / key stakeholder was very open to new ideas and enthusiastic about the project. • The school was due to have a new Headteacher (starting in September, when the action plan is due to be implemented).	Opportunity Potential threat
Attitudes to conflict	• This was not explicitly discussed, but was not raised as a potential threat.	N/a
Degree of willingness to discuss sensitive issues openly	• The Deputy Head and I had an open dialogue about sensitive issues regarding well-being and mental health, including personal experiences. • This openness was cascaded during data gathering • Opportunity was also given for stakeholders to raise any issues anonymously through various means. • Being based at the school, I was able to offer on-going support and advice to all staff members if needed.	Opportunity Opportunity Opportunity Opportunity
Degree to which the organisation's (school's) structure facilitates change	• The collaborative approach of the project seeks to flatten the hierarchy and reduce power imbalances, by asking all members to contribute. • The physical structure of the school building is segregated (primary and secondary phases), which may threaten communication and cohesion during the project.	Opportunity Threat
Degree of willingness to give people autonomy	• The Deputy Head was keen to gather representative views of the whole staff team.	Opportunity Opportunity

and support them in their actions	• She also acknowledged the importance of the stakeholder group having ownership of the data and having autonomy to develop the action plan.	
Attitudes to experimentation in processes and products	• Key stakeholder was willing to explore different methods and tools. • Key stakeholder was particularly open to using the ten-element map.	Opportunity Opportunity
Attitudes to sharing information	• Key stakeholder agreed to use the RADIO model and had a very positive attitude to openly sharing the information arising from the data collection phase. • We discussed how to group staff when gathering data, to maximise opportunities for honest and accurate data.	Opportunity Opportunity

2.4 Stage 4: Identifying stakeholders

Successful action research is a democratic, collaborative venture between the researcher and the client: "good research is conducted *with* people rather than *on* people" Heron and Reason (2001, p. 144). If change is forced, members of an organisation may 'keep their heads down' until time has passed, then resurface and continue as before (Thacker, 1994). Identifying stakeholders in the RADIO model is intended to maximise ownership of the project, thus increasing the likelihood of the organisation using research data to improve functioning (Timmins et al, 2003).

Selecting the relevant client or 'stakeholder' is an essential part of the OD process: projects can fail if the client is inappropriately defined (Cummings and Worley, 2005). Beckhard (2006) argues that for a project to be successful, top management must have a personal investment in the program and its outcomes, as they have the power to manage the change effort. In schools, this is usually the Head or Deputy Head (Dalin, 1993), but securing commitment from key stakeholders in schools can be challenging: Ashton (2009) described being 'passed' between different members of staff during this RADIO stage.

Initially, despite the concerns raised about staff well-being, I experienced some resistance from the Headteacher, who wanted me to prioritise individual casework. The Deputy Head, by contrast, had recently attended a 'work-life balance' workshop and was enthusiastic about the opportunity to invest in her own and others' well-being. I judged that she demonstrated the requisite determination, commitment, personal involvement and sense of ownership for a successful project (Gallant and Rios, 2006). The Headteacher agreed to the Deputy's role as initiative coordinator.

Of course, any *organisational* development project has many more stakeholders than just managers (Huczynski and Buchanan, 2001). The current project aims to improve the well-being of all staff, thus defining every member of staff as a 'stakeholder' at some level. The literature recommends meeting with representatives from the client group rather than the whole group (Huczynski and Buchanan, 2001; Dalin, 1993), but the Deputy Head wanted to gather diagnostic information from *all* staff in order to gain a truly representative picture of the current situation. We agreed that it would be feasible for all staff to participate in the data gathering phases, but that a smaller stakeholder group (which we termed the 'working party': the RADIO model refers to the 'coordinating group'; Timmins et al, 2003) would be selected to support the action planning and implementation phases. We discussed potential sampling strategies (such as random or quota sampling) to select members of the working party, but decided to recruit an opt-in opportunity sample of staff who shared our initial enthusiasm for the project, in order to maximise the chance of success.

2.5 Stage 5: Agreeing the focus of concern

Agreeing the focus of concern could be considered as a preliminary 'diagnosis' of the problem. The overlap between entry (clarifying concerns) and diagnosis (research methods mode) is acknowledged (Dalin, 1993) and is cited as a "prime example of the emergent nature of the OD process" (Cummings

and Worley, 2005, p. 73). It is recommended to seek early clarification of the organisational development issue, in order to inform choices about appropriate diagnostic and intervention activities (Cummings and Worley, 2005). Fullan (2003, p.29) warns, however, that "premature clarity is a dangerous thing" in complex change processes, as this tempts urgent, imposed change, rather than collaborative, adaptive change, informed by diagnostic information.

Hard	**Soft**	***Notes***
Timescales clearly defined / short to medium term	Timescales ill-defined / medium to long term	*Longitudinal project, spanning at least one year*
Resources clearly defined and reasonably fixed	Resources unclear and variable	*Resources needed to implement change unlikely to be identified until action planning phases*
Objectives are objective and quantifiable	Objectives are subjective and visionary	*Well-being is considered highly subjective, ambiguous and difficult to define*
Perceptions of the problem and its possible solution shared by all	Perceptions of the problem lack consensus	*Again, well-being means different things to different people*
Interest is limited and well-defined	Interest is widespread and ill-defined	*Well-being has differing levels of importance to different people*
Control is maintained within the managing group	Control is shared with people outside the managing group	*Collaborative approach seeks to give all members of staff opportunity to influence the change process*
Source of the problem originates from within the organisation	Source of the problem originates from outside the organisation	*Interestingly, the problem originated from within the organisation, which helps to 'harden' the problem.*

Figure 5: Analysis of the problem complexity, using the TROPICS factors (Paton and McCalman, 2008)

Understanding the change situation, which can be described on a continuum of 'hard' to 'soft' complexity (Paton and McCalman, 2008), can guide the design, planning and implementation of change (Senior and Swailes, 2010). Situations of 'hard' complexity lend themselves to quantification and an optimal solution, whereas situations of 'soft' complexity are more ambiguous and open to different interpretations (Senior and Swailes, 2010). Based on my own observations and reflections, I used Paton and McCalman's (2008) TROPICS factors to analyse the problem of staff well-being (Figure 5). This situation of soft complexity, characterised by the ambiguous, subjective and ill-defined problem 'staff well-being', strengthened the rationale to involve all staff and to use a clear diagnostic framework to structure data gathering.

3. Phase 2: Research Methods Mode

It is considered a central philosophy of OD work that change should be data-driven (Gallos, 2006), harnessing the *research* component of 'action research'. Emphasised in Lewin's early work, successful action depends on analysing the current situation in order to identify solutions (Burnes, 2006). This is often referred to as 'diagnosis': gathering necessary information to understand the organisation's current functioning and design interventions for change (Cummings and Worley, 2005). Joint, collaborative diagnosis can prepare the school for change (i.e. Lewin's 'unfreezing' stage; Dalin, 1993) and the consultant (the EP) can facilitate this process.

3.1 Stage 6: Negotiating a framework for data gathering

This stage is an opportunity to negotiate decisions regarding the methodology, methods, resources and timescales (Timmins et al, 2003), with complete flexibility afforded by the RADIO model (Timmins et al, 2006). The EP can offer research skills and knowledge of methodological literature, including

consideration of improving authenticity, validity and reliability of data; I met with the Deputy Head to discuss sampling and data collection methods, as well as highlighting important ethical considerations (BPS, 2010) that may otherwise have been overlooked.

Some authors recommend using diagnostic models or frameworks. Organisations are complex and it is not possible to consider all aspects simultaneously (Dalin, 1993), although the holistic, 'systems thinking' approach of OD work assumes that phenomena can only be understood "to be an emergent property of an interrelated whole" (Flood, 2001, p. 117). Using a model offers a systematic way to collect and analyse data (Noolan, 2006). Generic diagnostic models deconstruct elements of organisations, including task, structure, human resources, technology, culture, finance, leadership and relationships (Noolan, 2006; Cummings and Worley, 2005). Any diagnostic model can be used if it suits the purpose of the research (Noolan, 2006) and guides data gathering to understand the organisation's current functioning (Cummings and Worley, 2005). Specific to well-being, we utilised MacDonald and O'Hara's (1998) ten-element map (Figure 4) to structure the elicitation and integration of quantitative and qualitative data.

In-keeping with the participatory nature of action research, data gathering should also be a collaborative process (Cummings and Worley, 2005). We agreed to involve all staff in an hour-long 'information conference' (as recommended by Dalin, 1993), during an In-Service Training Day. This population comprised teaching staff (including teachers, teaching assistants and phase leaders), as well as school-based specialist support staff (such as Speech and Language Therapy Assistants and Outreach staff), and non-teaching staff (including administration staff, IT support, kitchen staff and site management). In order to collect illuminative, qualitative data, we established a series of simultaneous, self-led focus groups (with four-seven staff members in each), as a time-efficient way to gather multiple views (Morgan, 1997). Unlike individual questionnaires, focus groups encourage

discussion between participants and richer elaboration of ideas. The Deputy Head and I discussed the advantages of random or quota sampling to allocate groupings, but decided that staff-led opportunity groups may encourage more honest and uninhibited responses, leading to more authentic, valid and reliable data. Each focus group was tasked with discussing and recording their views about the current situation on a poster-sized ten-element map. As simultaneous facilitation of focus groups would be impossible, the posters contained questions phrased at the meso-level, for example, "how does the school give you messages about being valued and important?" (Appendix 1) and prompts (Krueger, 2007) to guide discussions (Appendix 2). Driven by the Deputy Head's request to evaluate the impact of the project quantitatively, staff members were also invited individually to rate their view of the current situation in each of the five areas using a ten-point scale (Appendix 3). This afforded a pre- and post- measure for evaluation.

From an ethical standpoint, I emphasised the importance of informed consent. We explained to staff that *attendance* at the information conference was expected as part of In-Service Training, although *participation* was not obligatory. The individual rating scales were offered as an optional contribution to be completely anonymous. Finally, through my role as a school-based Trainee EP and my training in counselling and consultation skills, I offered an 'open-door' approach for debriefing and advice-seeking.

3.2 Stage 7: Gathering information

This is quite simply the stage in which data collection is undertaken within the negotiated framework. Interestingly, the next stage of the RADIO model is 'processing information with stakeholders', but I would argue that 'data *analysis* by the EP' is a missing stage in the RADIO model. Sharing raw data with stakeholders has obvious limitations, in terms of the overwhelming quantity of data and the potential

biases from stakeholders over-focusing on particular aspects of data and minimising others. With their data handling skills, EPs are well-placed to analyse data to make them comprehensible and functional for stakeholders, as well as offering a more rigorous and comprehensive analysis than stakeholders may extract from the raw data.

Prior to processing information with stakeholders, I conducted both quantitative and qualitative data analyses. Quantitative analysis of staff members' (n= 53) scaling of the current situation revealed a wide range of scores (using a 10-point Likert scale), indicating individual differences in perceived organisational well-being for each area (Table 2). However, standard deviations of only 1-2 points for all areas demonstrate that the majority of scores were close to the mean. Figure 6 shows that 'environmental quality' and 'social participation' were rated as the best areas currently, whilst 'self-esteem', 'emotional processing' and 'self-management skills' were rated, on average, lower. These data may help to prioritise areas for improvement.

I also conducted a thematic analysis (Braun and Clarke, 2006) on the qualitative focus group data, illustrated in Figure 7. Discussion of these findings is offered in Professional Practice Report Four, at the point of evaluation, when pre- and post- data are available. I position findings in relation to existing literature and reflect on the value of action research to promote staff well-being.

	Environmental Quality	Self-esteem	Emotional Processing	Self-management Skills	Social Participation
Mean	6.98	4.77	5.34	4.98	6.47
Standard Deviation	1.84	2.17	2.19	2.15	1.95
Range	2 - 10	1 - 9	1 - 10	1 - 9	2 - 10

Table 2: Mean, standard deviation and range of individual rating scores (out of 10) for each area of well-being.

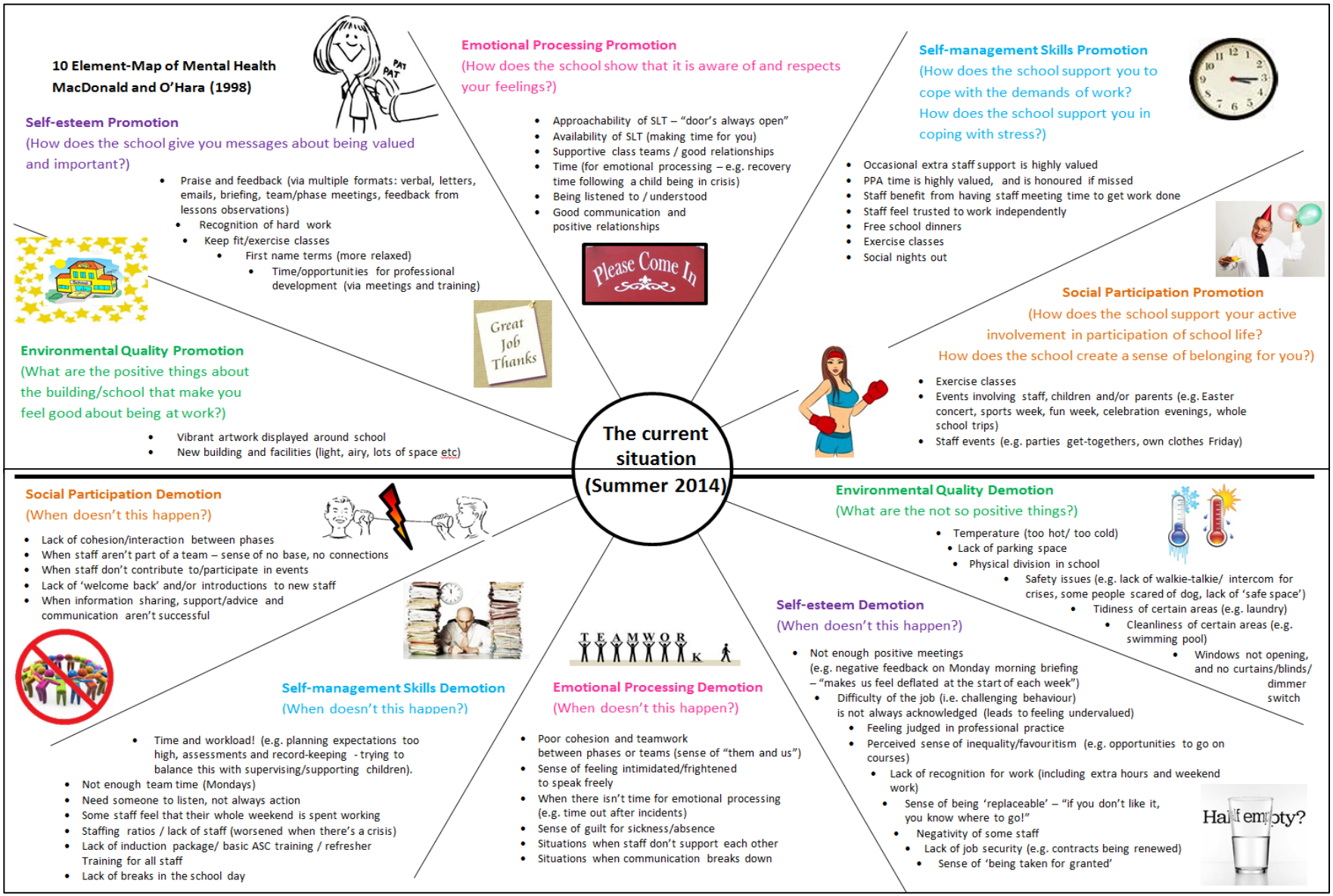


Figure 7: Summary of qualitative data using MacDonald and O'Hara's (1998) ten-element map

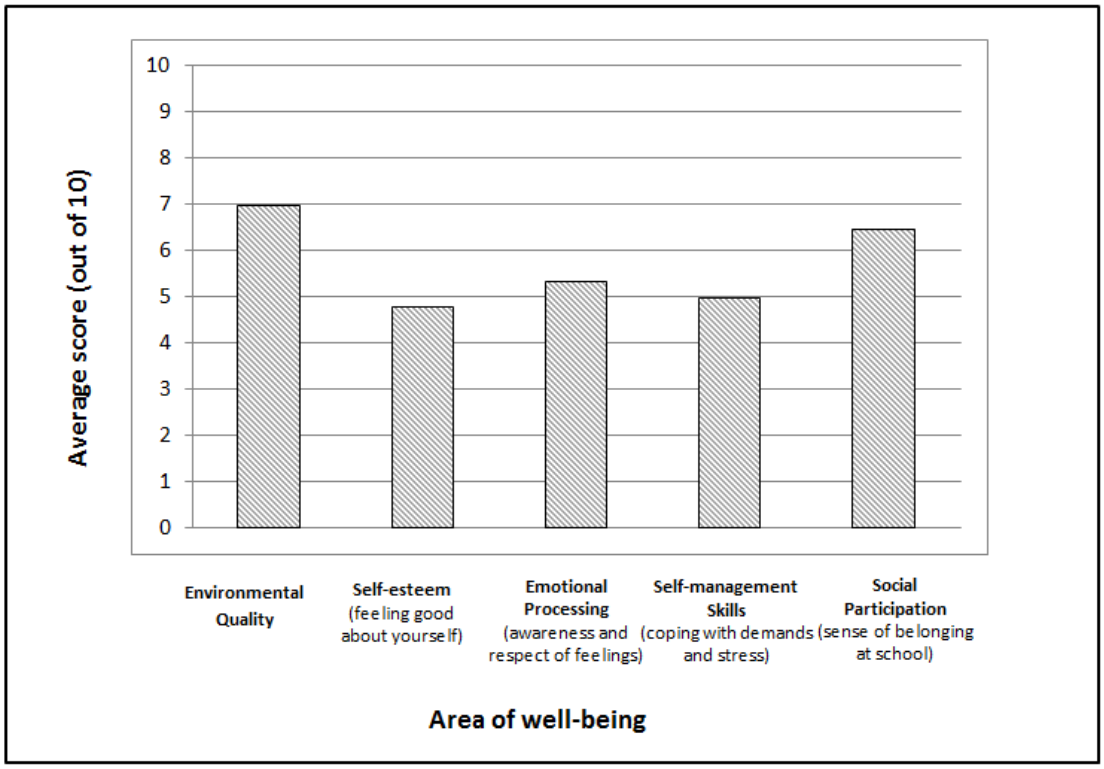


Figure 6: Bar chart to show the mean scores (out of 10) for each area of well-being, rated individually by staff members (n=53).

4. Phase 3: What are the next steps?

The third and final phase of the RADIO model, the 'organisational change mode' relates to the *action* part of the action research project. The phase is split into five stages: (i) processing information with stakeholders; (ii) agreeing areas for future action; (iii) action planning; (iv) implementation and; (v) evaluation. Whilst it is possible for the EP to withdraw after processing information with stakeholders, leaving the school to design and implement change, I would like to reflect on the role of the EP during the 'organisational change' phase of the action research cycle. This warrants further discussion within Professional Practice Report Four.

5. Discussion

5.1 Evaluation of the ten-element map

This project highlights the value of MacDonald and O'Hara's (1998) ten-element map as a conceptual model of mental health and well-being. The model has concurrent validity with present definitions in policy and research (DoH, 2011; Evans, 2011), indicating its contemporary relevance. The model's salutogenic approach identifies factors that both promote and demote mental health, which was valued by participants in incidental oral comments on the utility of the model. I believe that this, alongside the acknowledgement of social and cultural influences, generates an ethically sound way of exploring and developing staff well-being in schools.

The model facilitated structured data gathering and guided the focus group questions at the meso-level. Although Baker (2014) suggests that language needed to be simplified for use with children, Williams (2013) describes the map as accessible for non-specialists (i.e. parents, children, workers). Participants in the current study reported that the model was initially complex to understand, but following explanation, was a useful framework. The map also afforded a straightforward framework for data analysis as the themes were deductively pre-defined. Existing research suggests that the map is also a useful framework for action planning (Baker, 2014; Hall, 2010; Williams, 2013), which will be discussed in Professional Practice Report Four.

Similarly to Hall (2010), this project focused on well-being at the organisational (meso) level. One participant suggested that this approach may omit individual views, thus highlighting the potential benefits of using the map to consider individual micro-level influences on staff well-being. If future researchers use the map at multiple levels, it would be important to present the model in a staged,

comprehensible way, as well as considering the time costs: it took almost an hour to consider the meso-level.

5.2 Reflections on the RADIO model and implications for EPs

I will now reflect upon my use of the RADIO model so far, and the implications for EPs in negotiating OD work with schools. As a Trainee EP, for whom the RADIO model was originally developed, I found it a highly useful framework to guide my reading about OD. In action research, it is tempting to skip straight to data gathering and action planning, but the RADIO model highlights the importance of 'slowing down' during the initial entering and contracting stages to ensure a strong foundation for successful organisational change. I would, therefore, advocate its use by trainee and qualified EPs alike. Furthermore, I would recommend sharing the RADIO model with the client to emphasise the importance of each stage, particularly securing commitment from management stakeholders, which is fundamental to successful OD (Beckhard, 2006). The RADIO model also provided a useful framework for agreeing the expectations, structure and timescales of the project. I propose that the RADIO model should be updated to include both a literature review stage and a data analysis stage, to reflect the additional skills offered by EPs and to add transparency about the time implications when negotiating OD work with schools.

This project demonstrates that, through applying psychological knowledge and insights about successful organisational change, EPs are strongly positioned as effective process consultants in the early stages of action research. Whilst schools could independently conduct practitioner-research (Dickens and Watkins, 2006), EPs are well placed to offer additional insights and identify appropriate diagnostic models, through reviewing the literature. EPs can also make a beneficial contribution to *research* as well as *action*. In agreeing the focus of concern, EPs may help schools to realise that

“premature clarity is a dangerous thing” (Fullan, 2003, p.29), which can threaten the diagnostic formulations for organisational change. The powerful influence of organisational culture should not be underestimated, and EPs can support stakeholders to identify and address potential threats, thus ensuring a feasible project. Furthermore, with their knowledge of research methodologies, EPs are well-placed to support schools to gather and use data to inform action planning, including methods to elicit authentic, valid and reliable data and considering important ethical issues (BPS, 2010).

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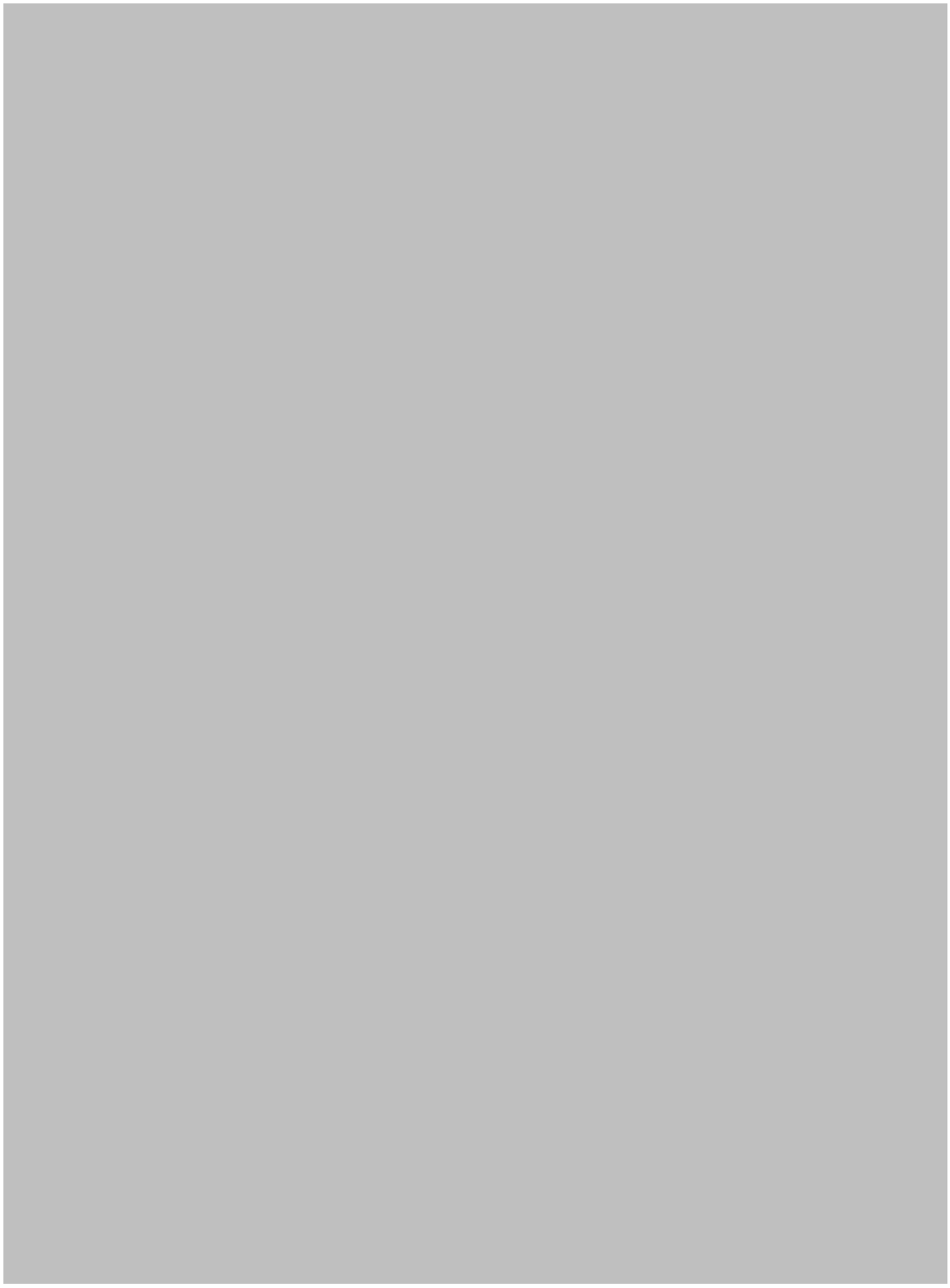
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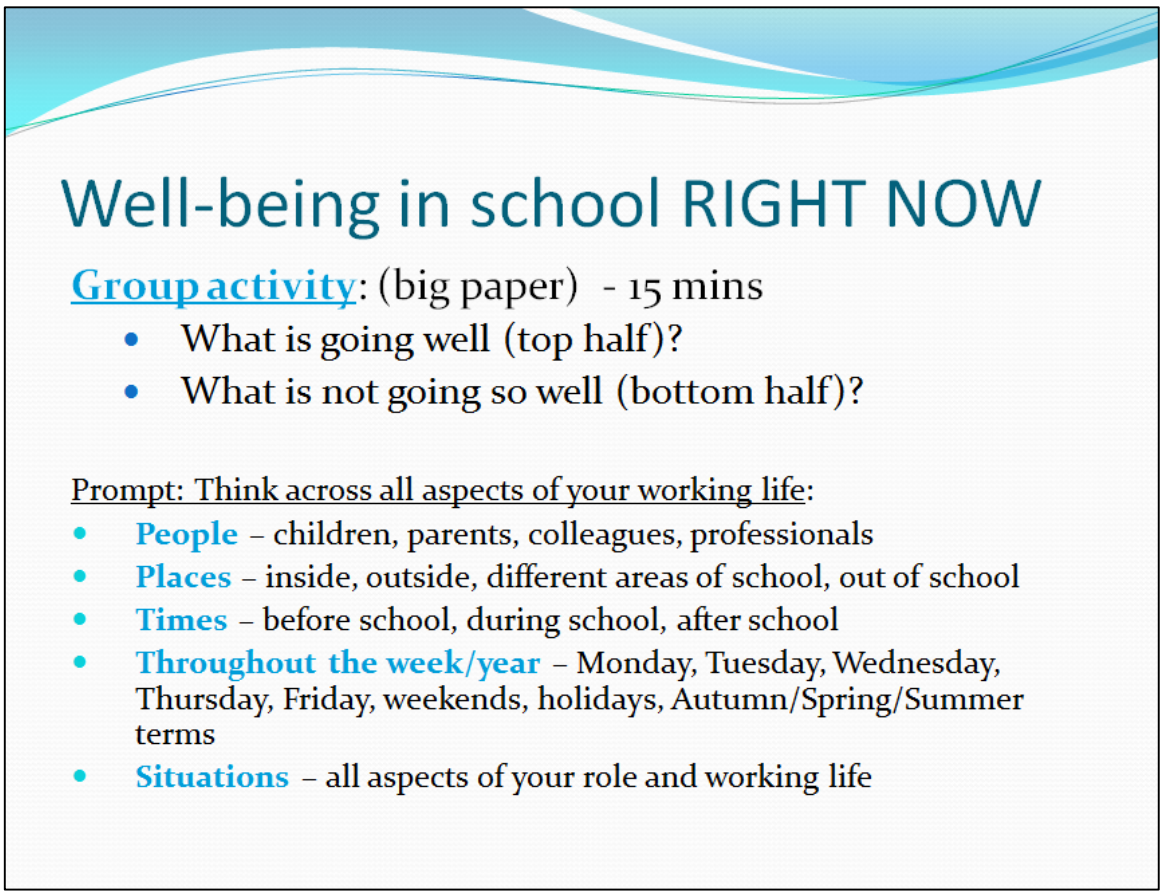
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PPR3 APPENDIX 1: QUESTION SCHEDULE FOR FOCUS GROUPS



PPR3 APPENDIX 2: QUESTION PROMPTS FOR FOCUS GROUPS



PPR3 APPENDIX 3: INDIVIDUAL RATING SCALES (OUT OF 10) TO ASSESS VIEWS ABOUT THE CURRENT SITUATION



CHAPTER FIVE

PROFESSIONAL PRACTICE REPORT FOUR

PROMOTING SCHOOL STAFF WELL-BEING USING THE 10-ELEMENT MAP:

AN ACTION RESEARCH PROJECT USING THE RADIO MODEL (PART 2)

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10. Implications, Recommendations and Reflections

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Appendix 1: Agenda for feedback and action planning meeting

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PPR4: PROMOTING SCHOOL STAFF WELL-BEING USING THE 10-ELEMENT MAP: AN ACTION RESEARCH PROJECT USING THE RADIO MODEL (PART 2)

Abstract

This paper describes the planning, action and evaluation phases of the collaborative action research project reported in Chapter 4, which sought to promote staff well-being in a West Midlands special school. This paper outlines and reflects upon activities during the final phase, 'organisational change mode', of the RADIO model (Research and Development in Organisations; Timmins et al, 2006), which has been applied to structure the project. Based on recommendations in the literature, I describe how the initial data about staff well-being were fed back to school staff, including to the whole staff group, and to the working party (stakeholder group). I also describe and reflect on the processes involved in action planning, implementation and evaluation, as well as reporting findings from the project evaluation. Evaluation data from both individual questionnaires (n=42) and focus groups (with the same sample) suggest that staff well-being had not improved as it had been planned during RADIO phases one and two (Timmins et al, 2006) of the project. I critically reflect upon various possible explanations for the apparently disappointing evaluation data, but I conclude by highlighting the importance of using this information formatively to feedback to the school, in order to continue the action research cycle (diagnosis, planning, action and evaluation; Freedman, 2006). This paper not only identifies specific recommendations to the school, but also highlights some important implications for educational psychologists in working with schools as organisations, and in seeking to undertake action research projects. I offer further recommendations for updating the RADIO model to become a useful and contemporary tool for educational psychologists when planning and implementing organisational development projects in schools.

1. Recapitulation: Project phases 1 and 2

Chapter 4 outlined the structure of the RADIO model (Timmins et al, 2006; Figure 1) and its application as a framework for the current action research[3] project. In Chapter 4, I reflected upon activities in Stages 1-5, the 'clarifying concerns' phase ('entering and contracting'; Cummings and Worley, 2005; Gallant and Rios, 2006), and introduced the aims the project: to improve staff well-being in a West Midlands special school. I explored definitions of 'well-being' and discussed existing literature relating to school staff well-being. I also considered relevant organisational and cultural issues relevant to the special school (Stage 3) and identified the key stakeholder (Stage 4): the Deputy Head, with whom I have worked alongside throughout the project. I described activities relating to stages 6-7, the 'research methods mode' ('diagnostic phase'; Cummings and Worley, 2005), driven by the fundamental principle of organisational development work that change should be data-driven (Gallos, 2006) and that *action* is driven by *research* (i.e. data about the current situation; Burnes, 2006).

2. Phase 3: Organisational change mode

The current report (Chapter 5) focuses on stages 8-12, the 'organisational change mode', which includes planning, implementing and evaluating change (Cummings and Worley, 2005). These activities are situated within the latter stages of the typical action research cycle of diagnosis-planning-action-evaluation (Freedman, 2006). OD work is rooted in the belief that change is action-oriented (Gallos, 2006) and these phases relate to the *action* component of 'action research'. I now discuss and reflect upon the processes and activities in stages 8-12 of the RADIO model (Timmins et al, 2006).

[3] The terms 'action research' and 'organisational development' are used interchangeably to refer to the current project, as the terms are often considered synonymous (Cummings and Worley, 2005): this is discussed further in Chapter 4.

Figure 1: The RADIO (Research and Development in Organisations) model, taken from Timmins et al (2006, p. 307).

RADIO phases	RADIO stages	Typical activities
Clarifying concerns	1. Awareness of need	School/EPS/LEA request or EPS suggestion
	2. Invitation to act	Contracting EP role in organisational development
	3. Clarifying organisational and cultural issues	Exploring opportunities and threats relating to initiative
	4. Identifying stakeholders	Agreeing processes for collaborating with stakeholders for feedback and discussion, e.g. coordinating group and initiative co-ordinator
	5. Agreeing the focus of concern	Identifying research aims and purposes.
Research methods mode	6. Negotiating the framework for data gathering	Issues and decisions regarding methodology, methods, resources and timescales
	7. Gathering information	Using agreed methods
Organisational change mode	8. Processing information with stakeholders	Sharing findings with stakeholders
	9. Agreeing areas for future action	Discussing findings in relation to organisation's needs and identifying areas action for
	10. Action planning	Stakeholder-led planning process
	11. Implementation /action	Stakeholders facilitating change within organisation
	12. Evaluating action	Stakeholders reviewing effectiveness of action and possibly requesting further EP involvement

3. Stage 8: Processing information with stakeholders

According the RADIO model (Timmins et al, 2006; Figure 1), this stage bridges the gap between the 'research methods mode' (Phase 2) and the 'organisational change mode' (Phase 3). I have included it in this Chapter, because I judge that the boundaries between 'feeding back' information to stakeholders and action planning be blurred.

The findings about the state of staff well-being at the start of the project were discussed and presented in Chapter 4 (Figure 7; Chapter 4) and this dataset was initially shared with the whole staff team during a staff meeting. This was intended to improve 'ownership' of the data by the whole client group, as recommended by Cummings and Worley (2005). Moreover, this served as an opportunity to conduct a validity check with staff, as recommended by Nadler (1977), by asking staff to comment on the accuracy of data and verify findings with further feedback and comments. The value of this was questionable, however, as no staff members gave further comments, despite being given multiple opportunities (during the staff meeting, or approaching me or any member of the working party individually afterwards, or putting an anonymous comment in the 'suggestions box', which had been in the staff-room throughout). Perhaps the lack of verification or further comment was due to individuals considering that they could not 'challenge' the group data, or perhaps this was due to apathy.

Presenting the data is, of course, only one aspect of feeding back: the main goal is to drive the findings towards action (Block, 2006). Feeding back is the most important step in the 'diagnostic' process (Cummings and Worley, 2005) and as Block (2006) reminds us, the purpose of data collection is to solve a problem or to achieve action. The feedback stage, including consideration of both the *content* and the *process* (Nadler, 1977), must, therefore, be carefully managed to ensure that data are used for constructive discussion and problem solving (Cummings and Worley, 2005).

Nadler's (1977) book referred to by Cummings and Worley (2005), focuses entirely on feedback processes and he offers some useful insights developed from his support of multiple OD projects. As Nadler (1977) points out, feedback has only the potential to *initiate* change; it cannot bring it about. He defines feedback as "any information about the system functioning which has the potential of *being used* to change the operation of the system" (Nadler, 1977, p. 70; italics added). He suggests,

therefore, that the *process* of feedback, in particular, needs to be carefully managed. The data were processed with stakeholders for a second time in more detail, with the working party of nine staff members, comprised of the Deputy Head, two senior leaders (who were also teachers), and six teaching assistants, which included representation from both the primary and secondary school phases. In order to facilitate a successful feedback meeting, Nadler (1977) recommends five features of successful feedback, which are outlined in Table 1, alongside reflections upon the current project.

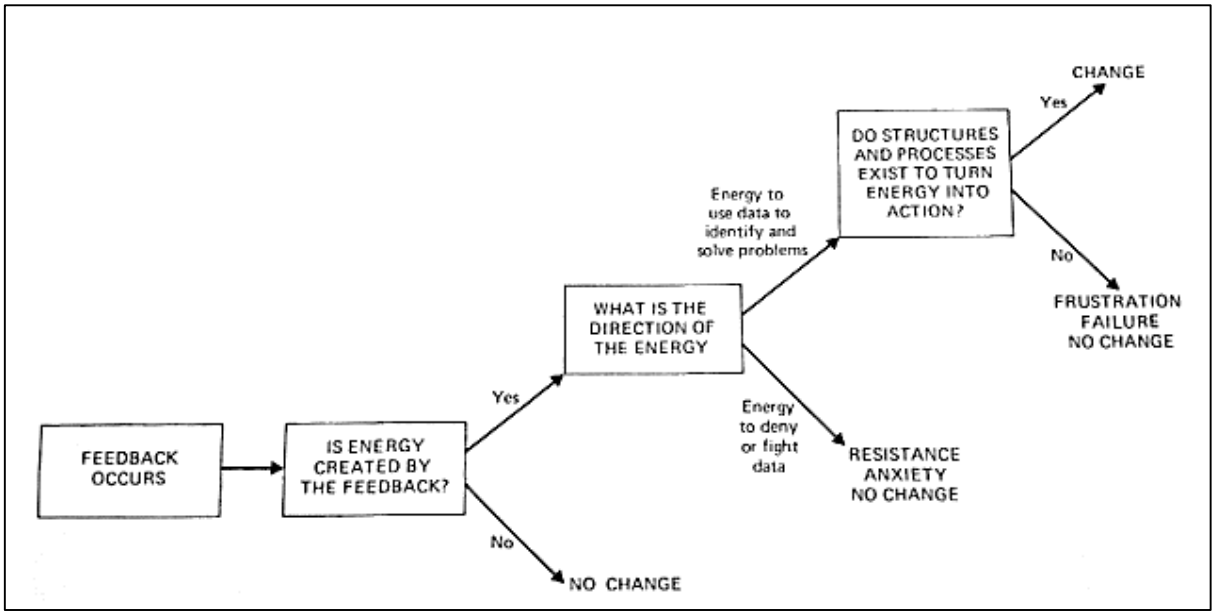
Table 1: Features of successful feedback meetings (Nadler, 1977)

Features of successful feedback meetings (Nadler, 1977)	**Reflections on the current project**
Motivation to work with data	The steering group was comprised of volunteers who wanted to be involved in the project. At the end, staff members appeared enthused and commented that they had enjoyed the session.
Structure for the meeting	Cummings and Worley (2005) warn that meetings can degenerate into chaos and aimless discussion. I planned a clear, timed structure for the meeting (agenda in Appendix 1) and this also included an action planning framework.
Appropriate attendance	The steering group was comprised of staff members from all hierarchical levels, creating 'proper representation'. This is considered to improve ownership, as well as participants' ability to address the problems suggested by the feedback.
Appropriate power	Nadler (1977) emphasises the importance of participants knowing which issues they can change and which they have no control over. The Deputy Head was present and was able to set boundaries where needed.
Process help	Cummings and Worley (2005) suggest that an OD practitioner can help the group to stay focused towards problem solving. As the Trainee EP, I led the feedback and action planning meeting, as a process facilitator.

According to Nadler (1977), data can be used to change organisations in two ways: (i) the 'motivating function' serves to energise behaviour and arouse feelings which drive people to change; and (ii) the 'directing function' is considered as an error-correction device and provides information about what to do in order to achieve certain goals. He argues that "energy must be both created (that is, aroused) and directed (guided towards certain goals)" (Nadler, 1977, p. 145; Figure 2). Upon reflection with the

Deputy Head, and perhaps as a result of the features of the meeting (described in Table 1), we judged that the energy created in the working group meeting was positive, which, we interpreted, did drive energy towards action planning.

Figure 2: The motivating (energy) and directing (action) functions of feedback (Nadler, 1977, p. 146)



4. Stage 9: Agreeing areas for future action

This stage of the RADIO model (Timmins et al, 2006) was largely overlooked as a discrete stage in the current project. In seeking to foster 'ownership' of the data by the working party, I had planned to support them to refine the specific aims and priorities for action, based on the summarised data provided (presented in Chapter 4; Figure 7). Upon reflection, this proved highly time-consuming and perhaps over-ambitious for the initial working party meeting. This is acknowledged by Dalin (1993), who suggests that agreeing priorities is challenging when there are many to choose from. In hindsight, having more regular working party meetings could have enabled development of a more specific, measurable, achievable and realistic action plan. This was, however, limited by my own capacity, working within a newly established traded Educational Psychology Service ('EPS' hereafter) context. The project was initially negotiated within a needs-led EPS context, in which there was more flexibility

to negotiate my support and involvement in the project. At around the time of action planning, the EPS transitioned to a traded service. This had significant pragmatic implications for constraining my intended on-going involvement with the project's implementation and evaluation, which, alongside limitations to the time offered by the working party, prevented more intensive working, which may have optimised project outcomes.

5. Stage 10: Action planning

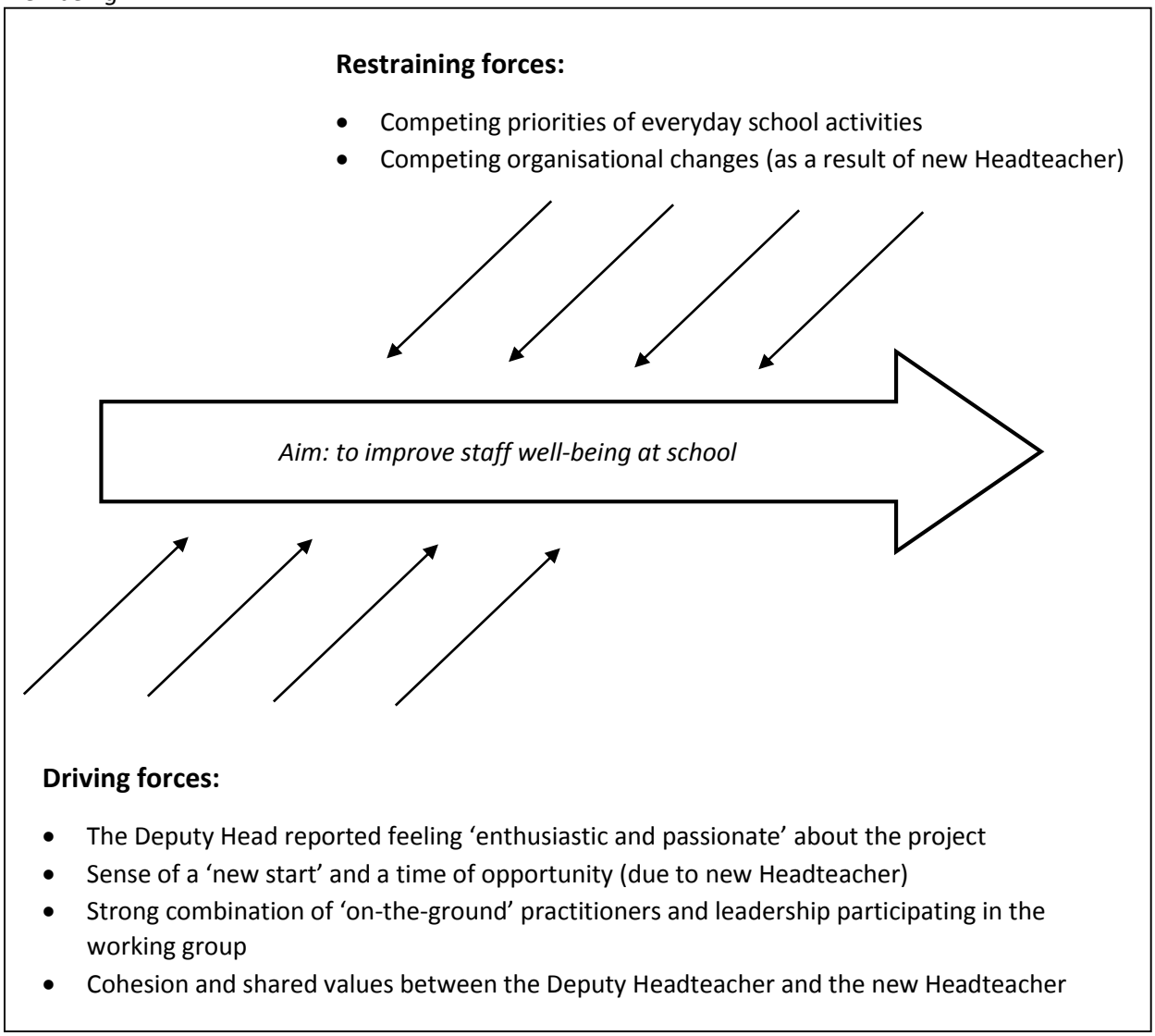
The RADIO model (Timmins et al, 2006; Figure 1) describes this a 'stakeholder-led' process, further emphasising the importance of ownership, as advocated by Cummings and Worley (2005). The action planning was conducted during the 'working party' meeting, because Dalin (1993) suggested that the 'steering committee' should be responsible for planning and implementing the 'development programme' or action plan. The action planning stage is likened to creating a 'road map' for change (Cummings and Worley, 2005). In order to facilitate this, I designed an action planning proforma (Appendix 2), organised by the five key areas from the 10-element map (MacDonald and O'Hara, 1998; environmental quality, self-esteem, emotional processing, self-management skills and social participation). This proforma sought to follow advice to elicit specific, discrete change tasks (the 'strategies') in order to achieve the agreed goals (the 'aim'; Cummings and Worley, 2005). The 'strategies' column asked participants specifically "how will we achieve the aim?" and sought to follow the recommendation that "the more the feedback meeting can address *what to do*, the better chance of implementation" (Block, 2006, p. 391, italics added). The action plan also provided a space to plan the resources needed, in order to prepare for sustaining the change (Cummings and Worley, 2005), as well as asking participants to suggest a realistic time frame for implementation and to identify a lead responsible person for the action. Finally, the action plan required participants of the working party to

identify the 'success criteria' for each aim: "how will we know if we have achieved the aim?" Firstly, this sought to encourage the suggestion of more specific strategies/actions, and secondly it sought to shape the framework for evaluation (RADIO Stage 12; Timmins et al, 2006), which is often overlooked in the planning stages (Nadler, 1977), but should be considered during 'entering and contracting' stages (Livingstone, 2006).

6. Stage 11: Implementation/Action

During the transition from action planning to action, I argue that it is important to revisit Stage 3 of the RADIO model (Timmins et al, 2006; Figure 1), thus highlighting the on-going importance of organisational culture. Stage 3, 'clarifying organisational and cultural issues', is concerned with identifying threats and opportunities for the project, which I judge to be particularly important when considering how planned actions (Stage 10) will be implemented (Stage 11). One commonly cited framework for identifying threats and opportunities is the 'force field analysis', which is a technique for analysing the forces for and against the desired change and was originally developed by Lewin in the 1950s (Senior and Swailes, 2010). The model affords analysis of both 'driving forces' (the forces pushing for change) and the 'restraining forces' (the forces working against change; Palmer et al, 2009). In order for the desired changes to occur, the driving forces must be stronger than the restraining forces (Senior and Swailes, 2010). During a discussion with Deputy Head, immediately following the action planning stage, we applied this model to the current project: we identified potential driving and restraining forces as illustrated in Figure 3.

Figure 3: Force field analysis of potential driving and restraining forces on efforts to improve staff well-being



Stage 11 of the RADIO model, 'implementation and action', (Timmins et al, 2006; Figure 1) is often referred to as the 'intervention' stage in the OD literature, which includes implementing a set of planned actions (i.e. from the action plan) to improve organisational effectiveness (Cummings and Worley, 2005). These 'interventions' can include standardised programs, or unique interventions which are tailored to a specific organisation: the action plan in the current project (Appendix 2) was evidently highly individualised to the special school and was based on specific aims, identified within the framework of the 10-element map (MacDonald and O'Hara, 1998).

In line with the consistent emphasis on 'ownership' (Cummings and Worley, 2005), the RADIO model suggests that stakeholders should implement the planned actions within the organisation (Timmins et al, 2006). However, Dalin (1993) suggests that the consultant (myself, as Trainee EP, in this case) should be concerned to follow the implementation process, in order that the school achieves its goals. Cummings and Worley (2005) warn that the initial excitement of a project can often dissipate during the implementation phase and that the OD practitioner has a role to play in sustaining momentum. Within the one-year timescale agreed for implementation, I met only once with the Deputy Head to hold an 'implementation review meeting' (Appendix 2: annotations). Again, my involvement was limited by the traded context of the Educational Psychology Service, as described in Section 4. Cummings and Worley (2005) describe this as a kind of early evaluation, in which 'implementation feedback' provides information about whether the action plan (intervention) is being successfully implemented. During this meeting, we briefly identified and 'ticked' the actions that had been completed or that were in progress. I reflected that this meeting seemed slightly rushed and superficial: I sensed that perhaps the restraining force of 'competing priorities' (Figure 3) was beginning to have an influence, and indeed questioned whether the initial enthusiasm would be sufficiently sustained in order to improve staff well-being.

7. Stage 12: Evaluating action

'Evaluating action' is positioned as the final stage in the RADIO model (Timmins et al, 2006; Figure 1) and is described as a way of providing feedback to members of the organisation about both the *progress* and *impact* of the intervention/action plan (Cummings and Worley, 2005). This involves feedback about whether the intervention/action has been implemented as planned and whether it has

had the desired outcome (Cummings and Worley, 2005). In particular, a planned, systematic evaluation can provide useful information about the effects of the 'intervention' or action plan (Nadler, 1977).

7.1 Gathering evaluation data

Several authors suggest that the framework for evaluation should be planned at the entering and contracting stages (Nadler, 1977; Livingstone, 2006; Cummings and Worley, 2005). In the current project, this was negotiated with the Deputy Head in Stage 6, 'negotiating a framework for data gathering (Chapter 4). The evaluation stage is considered to be another opportunity for data gathering and analysis, and therefore careful selection of appropriate measures and research design is important in order to improve the internal validity (Cummings and Worley, 2005). As argued in Chapter 4, I suggest that the EP has an important role to play in the collection and analysis of data, in offering research skills and knowledge of research methodologies. We agreed to gather further quantitative and qualitative data from both individual questionnaire and focus groups.

The individual questionnaire (Appendix 3) sought to collect individually-rated quantitative data about the current state of staff well-being across each of the five areas in MacDonald and O'Hara's (1998) 10-element map. This was identical to the individual rating scales distributed at the initial data gathering phase and served to provide a comparison of pre- and post- measures; findings are presented in Figure 4, Figure 5 and Table 2. Staff members were asked to indicate whether they were present at the 'launch' of the project (one year previously), which allowed analysis to account for this. The individual questionnaire also asked staff members to rate their overall sense of whether well-being had improved (using a Likert scale: 5 – improved a lot; 4 – improved somewhat; 3 – the same; 4 – a bit worse; 5 – a lot worse). Finally, the individual questionnaire also asked for qualitative feedback about

'what is going well' and 'not going well' as well as inviting suggestions for further steps to promote positive well-being at school. These findings are presented in Table 3.

Individual questionnaire data were gathered from 42 members of staff at evaluation, a decrease from 53 staff members during the initial data gathering phase (Chapter 4, Section 3.2). As the number of employed staff was reported actually to have increased, the reduced number at evaluation (n=42) may have compromised the representativeness of the sample. Although all staff members were invited to participate, as a representative group is desirable (Nadler, 1977; Senior and Swailes), there was a high attrition rate, perhaps linked to the 'restraining force' (Figure 3) of competing priorities, or possible dissipation of initial excitement for the project (Cummings and Worley, 2005). At evaluation, 32 members of staff (of 42) reported that they had been present at the initial data gathering phase, indicating that 10 members of the 42 staff at evaluation were either new to the school, or had been absent from the initial data collection phase.

During the initial data gathering phase (RADIO Stage 7; Timmins et al, 2006; Figure 1), qualitative data were sought from multiple focus groups, asking "how does the school promote and demote staff well-being?" across each of the five areas of MacDonald and O'Hara's (1998) 10-element map. In the evaluation phase, instead of gathering further comparative data using the same method, we agreed to ask focus groups to evaluate the action plan directly. This included both quantitative ratings about whether each of the action plan's aims had been achieved (using a Likert scale: 1 – not at all; 5 – very well), and qualitative data asking "what has gone well?" and "what could be improved?" The focus groups were orchestrated similarly to the initial data collection, comprising a series of simultaneous self-led focus groups. The groups comprised four-seven members of staff, and key stakeholders (members of the working party) were distributed equally amongst the groups. In order to encourage

the groups toward task completion, group roles were assigned: a 'scribe' to write the group's responses and a 'time-keeper' to move the group forward at 5-mintue intervals.

7.2 Findings of the evaluation

Disappointingly, Figure 4 and Table 2 illustrate that, in each area, mean individual ratings of staff well-being appear to have slightly decreased (i.e. worsened) from the initial data gathering phase to the evaluation phase (one year later). There are several possible explanations, which are discussed in Section 8.

Interestingly, the wide range of scores (Table 2) indicates that individual perceptions of staff well-being are varied. Overall ratings of staff well-being (on Likert scale of 1-5) are illustrated in Figure 5, which shows that the majority (mode number) of staff members rated staff well-being as "still the same", perhaps representing a bias of central tendency. Similarly, the central value of 3 was also the mean average, with balanced frequencies across both positive scores (Likert scores of 3.5-5) and negative scores (Likert scores of 1-2.5). This suggests that there are individual differences in perceived well-being at school, with some staff perceiving improvements and others perceiving that well-being in school had deteriorated. Ideally, with fewer limits to time or resources, follow-up interviews with those with extreme scores could provide useful additional feedback. In the current project, however, this was neither feasible nor possible due to the anonymity of questionnaires.

Figure 4: Mean individual ratings of staff well-being pre- and post- implementation of the action plan (one year later)

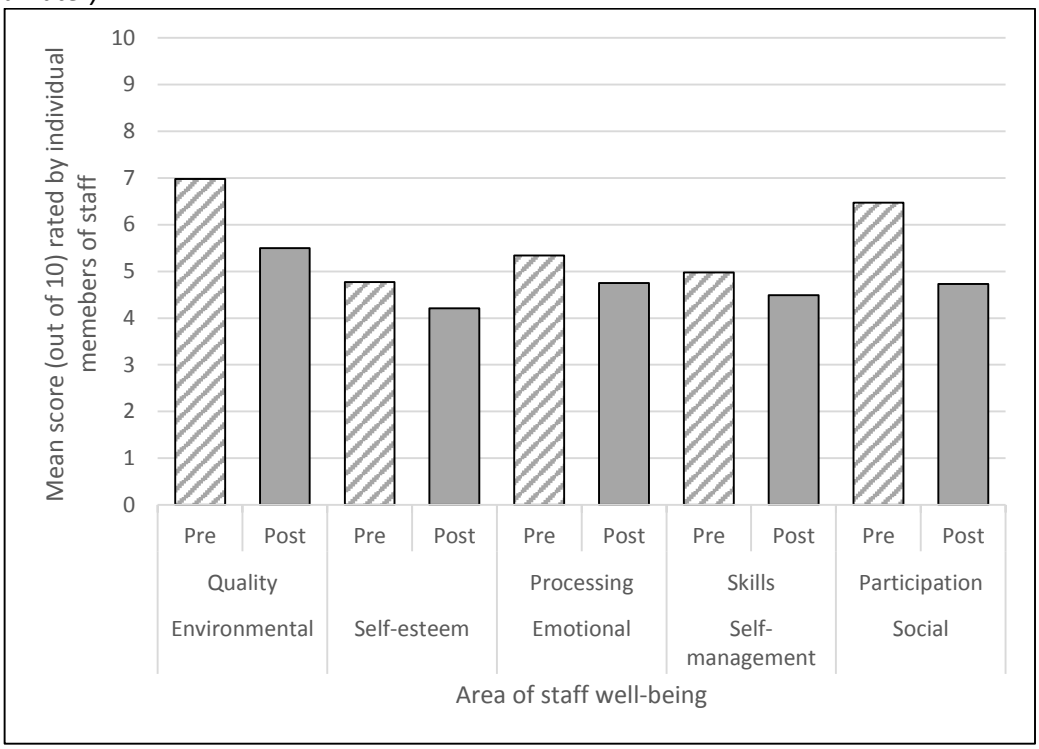


Figure 5: Frequency of individual ratings of overall staff well-being (using a 10-point Likert scale)

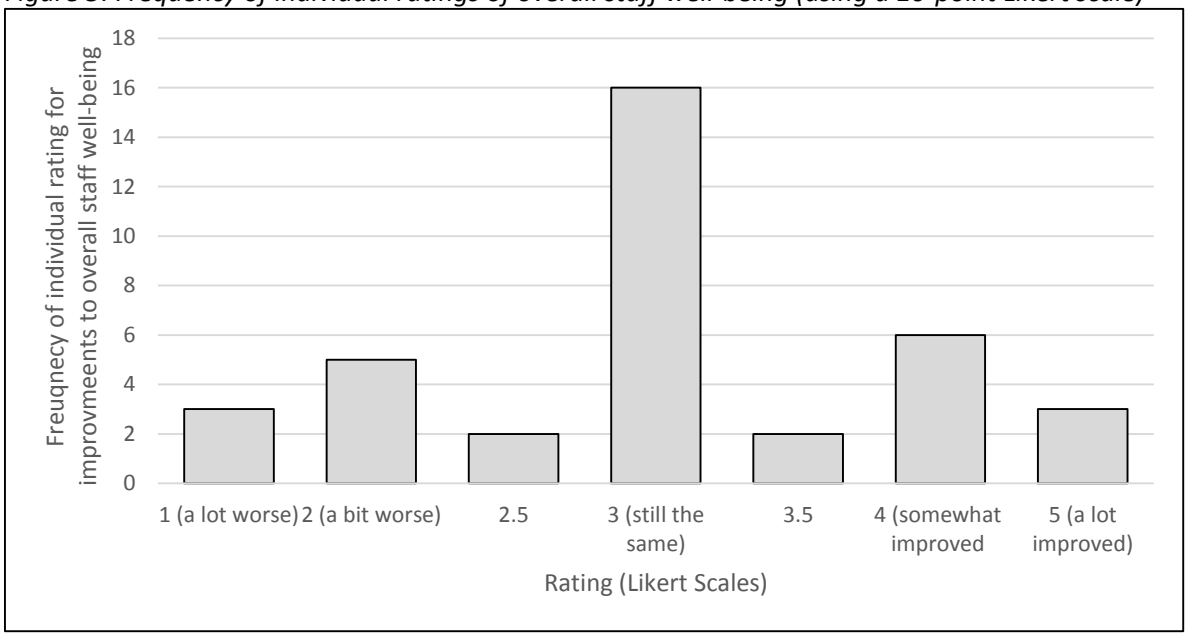


Table 2: Means and standard deviation of individual ratings of staff well-being, for pre- (n= 53) and post (n= 42) implementation

	Environmental Quality		**Self-esteem**		**Emotional Processing**		**Self-management Skills**		**Social Participation**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Mean	6.98	5.50	4.77	4.21	5.34	4.75	4.98	4.49	6.47	4.73
Standard Deviation	1.84	1.99	2.17	1.99	2.19	2.17	2.15	2.10	1.95	2.03
Range	2 - 10	2 - 9	1 - 9	1 - 9	1 - 10	1-10	1 - 9	1 - 9.5	2 - 10	1 - 9

The qualitative data from the individual questionnaire (Table 3) added some illuminative feedback. I thematically grouped similar comments and provided frequency scores (shown in brackets; Table 3) for comments to indicate their perceived importance and I rank-ordered these accordingly. I noted that the proportion of positive to negative comments was heavily negatively weighted, perhaps indicating a negativity bias. This could be explained by staff believing that the questionnaire provided an opportunity to be 'heard' about difficult issues, which would not normally be discussed in school. In order to be most constructive to the school, I reframed these negative comments into ideas to promote well-being, alongside suggestions made explicitly by staff (Table 3).

Table 3: Qualitative evaluation data from individual questionnaires (numbers in brackets represent the number of individuals who made the comment)

What is going well?	**What could further promote positive well-being?**
• CPD opportunities are improved (4) • Improved teamwork (4) • Caretaking has improved (3) • SLT[1] are more approachable (2) • Safer environment (2) • More positivity generally (2) • 'Return to work' meetings are helpful (1)	• Improve staffing issues, including: consistency, cover for absence, crisis support, and 'time out' after challenging incidents (9) • Team building events or staff outings to boost staff morale (7) • More frequent and more genuine praise (6) • Better open and honest communication between SLT[1] and staff members (5) • More support to manage challenging behaviour both preventatively and reactively (4) • Staff access to counselling and/or supervision (2) • Ensure time is made for 'return to work' meetings (1) • More support for workload expectations (1)
[1]SLT = Senior Leadership team	

Quantitative feedback from the focus groups (Table 4) was useful to evaluate how well each of the project's aims had been met. The most successfully addressed aim was the perception of staff safety

around school, and many groups commented that the introduction of a 'walkie talkie' radio system to request support during incidents of challenging behaviour was beneficial. The focus group data also indicated improvements to cleanliness and tidiness around school. It is noteworthy that both these aims relate to the 'environmental quality' area of well-being and are both linked to tangible, visible outcomes. The focus group data also provided useful formative feedback about which areas were perceived to be least successfully addressed, therefore informing the recommendations to the school about the next phase of the project (discussed in Sections 9 and 10).

Table 4: Mean focus group scores attributed to each project aim, using 5-point Likert scales (Items in bold represent the lowest scoring items)

Area of well-being (from MacDonald and O'Hara , 1998)	**Project focus (aim/success criteria)**	**Mean score (1= not at all achieved; 5 = very well achieved)**
Emotional Processing	**To increase time for recovery and emotional processing (after difficult incidents)**	**2.1**
	To build opportunities for staff to be listened to/ feel understood	2.6
	To improve staff attendance issues and reduce guilt for genuine sick leave	**2.0**
Self-esteem	To value and utilise individual staff members' strengths and skills	2.6
	To improve praise and positive feedback to staff	2.7
	To increase positivity around school	2.3
Environmental quality	**To improve the availability of parking spaces at/near school**	**1.4**
	To improve cleanliness and tidiness around school	3.0
	To improve personal safety	4.0
	To improve the temperature around school	**1.9**
	To consult with staff about introducing a uniform	**1.0**
Social participation	To improve cohesion throughout the school	2.7
	To improve staff members sense of belonging	2.7
	To build morale and team working throughout school	**1.1**
Self-management skills	To improve CPD (Continuing Professional Development) opportunities for all staff	2.9
	To support staff to manage their workload	2.2

Focus group qualitative data echoed the comments made in individual questionnaires (Table 3; an indication of internal validity), and comments from the focus groups were adequately represented within the themes of the individual comments. I judged, therefore, that it would not be time-effective, nor of additional benefit to the school, to analyse and present the focus group qualitative data separately.

8. Discussion of findings

There are two possible overarching explanations for the findings that staff well-being was perceived to have remained approximately the same overall, with a slight perceived decrease in each specific area of well-being: (i) the data lack validity; or (ii) the data *are* valid and accurately represent staff views about well-being in school.

Firstly, it is possible that the validity of data is compromised by some methodological limitations. The pre- and post- intervention staff sample were markedly dissimilar. There was a 21% attrition rate in the total number of participating staff in the data collection at evaluation, compared to pre-intervention, despite an overall increase in the number of staff members employed by the school. Furthermore, only 60% of the staff who participated in the initial data collection phase were present during the evaluation phase, and 12 members of staff were new participants at evaluation. These factors are likely to have affected the representativeness of the data. Overall findings were not distinctly different when I controlled for new members of staff, by removing their data. This indicates some level of consistency in staff views, although it is possible that this relatively small sample size would not create enough power to make a difference. Unfortunately, as data were all collected anonymously, it was not possible to link individual pre- and post- data to compare individual perceptions of staff well-being before and after implementation of the action plan.

In addition, feedback from a few members of staff, who approached the Deputy Head following the focus groups, suggests that they believed the focus groups to be overly negative and not representative of their views. In liaison with the Deputy Head, these staff members were offered the opportunity to re-record their scores and comments on a separate focus group sheet, in order that their views would be better represented. They did not, however, take up this opportunity, perhaps due to the compromised anonymity in doing so, or due to the additional time cost incurred. This could, at least in part, explain the generally negative feedback from the focus groups and low scores regarding implementation of the project aims.

As a further reflection, it is possible that focusing at only the meso-level (or school level) of well-being (Chapter 4, Figure 4) led to neglect of *individual* staff well-being at the micro-level. It is possible that the quantitative and qualitative evaluation measures used did not sensitively distinguish between subjective well-being at the individual-level versus at the school-level.

Secondly, it is possible that even with consideration of these limitations, staff members genuinely perceive that staff well-being has remained the same overall (or worsened on individual ratings of specific areas of well-being). It is possible that the project aims were not perceived to have been realised, or indeed that individuals within the organisation perceived them to influence their overall well-being. Despite the pessimistic title of his chapter, “why transformation efforts fail”, Kotter (2006) offers a useful eight-stage framework against which to reflect upon the possible reasons why the current action research project did not show significant positive outcomes as desired.

Table 5: Kotter's (2006) Suggested Explanations for 'Failed' Projects

Explanation	Description	Reflections on the Current Study
1 Not establishing a great enough sense of urgency	Kotter (2006) suggests that without motivation from organisation members, projects are unlikely even to begin.	This relates to Stage 1 of the RADIO model, 'awareness of need' (Figure 1) and in the current project, I consider that strong foundations were laid: a significant need to improve staff well-being was identified and sufficient motivation and commitment from the Deputy Head was secured (RADIO Stage 4, 'identifying stakeholders'). I conclude, therefore, that lack of initial urgency does not explain the evaluation findings.
2 Not creating a powerful enough coalition	The stakeholder group may lack sufficient power to lead change, including successful team-working and group cohesion.	The current project did, however establish a strong stakeholder group ('the working party') together with the leadership and 'power' of the Deputy Head. Furthermore, the level of participation from the new Headteacher, in the context of multiple changes following her appointment, may have reduced the power of the stakeholder group. I conclude that this factor alone cannot explain the current project's evaluation findings.
3 Lacking a vision	Kotter (2006) suggests two stages: (i) creating a vision; and (ii) developing strategies to achieve the vision.	The current project did not entirely 'lack' a vision and efforts were made to focus the action planning, drawing upon recommendations in the literature. Upon reflection, it seems that the situation of soft complexity (discussed in Chapter 4, Section 2.5) made the action plan difficult to define and measure. The literature suggests that feedback data should be reduced to a manageable number of items (Block, 2006). I had considered that this was achieved, as each of the five areas of well-being was reduced to 3-5 targets. However, in hindsight, perhaps there remained too many aims overall. I recommend to the school, therefore, the entire action plan should now be reduced to 3-5 focused targets overall. Furthermore, the action planning meeting was possibly too rushed and not specific enough (Cummings and Worley, 2005). I recommend to the school that several on-going meetings would be beneficial (Farquhar, 2006).
4 Undercommunicating the vision	Should use every vehicle possible to communicate the vision	In the current study, there was one initial feedback session to the whole staff about the project's aims and action plan. Upon reflection, this could have been further developed by the DH, who could have kept staff members regularly informed about the project, and any actions that were already underway (see 'short-term wins' below).

5	**Not removing obstacles to the vision**	Kotter suggests that not taking action to remove or reduce potential obstacles may prevent successful organisational development.	Despite completing a force field analysis (Figure 3), it is possible that the restraining forces had stronger power than the driving forces, marked by the rushed implementation review meeting with the Deputy Head and attrition rates pre and post implementation of the action plan. Consideration of how to remove or reduce these obstacles should be considered within the school. One possibility is the creation of more 'short-term wins' (see below).
6	**Not systematically planning for and creating short-term wins**	Projects can lose momentum if there are no short-term wins, including compelling evidence of them. This involves planning for visible improvements and creating them, including recognising and rewarding staff members in the short term.	The current project highlighted the difference between *hoping for* short-term wins and actually *creating them*. In hindsight, this project needed more tangible outcomes, strategies or events. Interestingly, the highest rated improvement related to more tangible aims (from the environmental area of well-being, including personal safety and cleanliness/tidiness).
7	**Declaring victory too soon**	Reinvigoration of the process is often needed in order to sustain efforts towards positive change.	During the implementation review, the Deputy Head and I briefly 'ticked' to say that things were 'in progress' (Appendix 2: annotations), which may have created a false sense of security, and a lack of precise focus on actions and tangible outcomes.
8	**Not anchoring changes in the corporation's culture**	Kotter suggests that change sticks when it becomes "the way we do things around here" (Thacker, 1994)	In the current project, there are still many of the planned changes that need to be initiated, so the project is not yet at the stage of embedded changes in the school's culture.

I consider that the lack of improvement to staff well-being at follow-up could also be explained by other factors, not in Kotter's (2006) framework. Firstly, there was a major organisational change within the school at the same time as the project: a new Headteacher. This is likely to mean that several other changes to organisational structure and culture were taking place at the same time as the staff well-being project. As with any changes, the Headteacher's new changes may have been met with some resistance, and evaluation findings may represent dissatisfaction with other particular changes within school at the same time. With such a situation of soft complexity (Paton and McCalman, 2008; Chapter 4, Section 2.5), it would be difficult to separate these issues, but this furthers highlights the importance of the force field analysis, as well as steps to reduce the restraining factors.

Secondly, I consider that during the initial data gathering phase, staff members may have felt positive about the possibilities for change, and their expectations of potential improvements to staff well-being became raised. Cummings and Worley (2005) suggest that staff may develop unrealistic expectations and this may have created a sense of disillusionment at evaluation, explaining the negative scores. Cummings and Worley (2005) also suggest that it is not uncommon for things to get worse before they get better and they recommend that feedback should lead to beginning the action research change cycle again. This is echoed in my recommendations to the school.

9. Next steps: Post-evaluation

Cummings and Worley (2005) suggest that there are two possible outcomes arising from project evaluation: (i) the implementation of the action plan has been successful; or (ii) evaluation data indicate a need for further intervention. The latter is certainly the case in the current project. These

outcomes, they argue, lead to decisions about whether to continue the action plan, modify it or terminate the project.

The RADIO model (Timmins et al, 2006; Figure 1) suggests that the stakeholders might request further EP involvement following evaluation. In the current project, the Deputy Head and I had previously agreed during the 'clarifying concerns' phase of the process, that my involvement would terminate following the evaluation. We had, of course, anticipated positive evaluation data and that staff well-being would be perceived to be improved, in order that 'termination' of the project would focus on sustaining positive changes. Findings from the evaluation, however, suggest that, whilst there are some small successes, there are also many areas that would benefit from further intervention. It was agreed in advance that I would provide feedback to the school in the form of a report (as suggested by Livingstone, 2006), although this was originally planned to be a summative report detailing the project and its outcomes.

In rejecting the conclusion that the project has simply been a 'failure' (Kotter, 2006), I recommend formative application of evaluation data to identify the next steps in the action research cycle. Due to my role as process consultant, this feedback has the additional benefit of offering process insights specific to the current project (including detailed insights into organisational culture) which could serve to enhance the implementation of further actions. My key recommendations to the school are summarised in Section 10.

10. Implications, Recommendations and Reflections

10.1 Recommendations to the special school

I consider that the RADIO model is missing a final stage, 'feedback and recommendations', in which evaluation data are fed back to staff in the *cycle* of action research (planning-action-evaluation; Dickens and Watkins, 2006). From the position of (Trainee) EP and process facilitator, I believe that EPs are well positioned to offer feedback and recommendations to the school, not only on the *content* of evaluation data and further suggestions to improve staff well-being (i.e. what to do), but also on the *process* (i.e. how to do it).

Firstly, in feeding back to the school, I believe that it is important to celebrate the small successes of the current project. Individual feedback data suggest that some members of staff did perceive improvements to overall staff well-being and indicated the following particular successes: improvements to CPD opportunities, improved teamwork and more positivity, improved caretaking, cleanliness and tidiness, more approachable SLT, as well as a perceived sense of improved personal safety.

Based on evaluation data and staff suggestions for further improving staff well-being, I fed back to the school that the project has a firm foundation and recommended that the staff well-being project should continue. I suggested the following priority areas of focus (ranked from most to least important):

- Improve staffing issues, including: consistency, cover for absence, crisis support, and 'time out' after challenging incidents
- Team building events or staff outings to boost staff morale

- More frequent and more genuine praise
- Better open and honest communication between SLT and staff members
- More support to manage challenging behaviour both preventatively and reactively
- Seeking ways to improve the temperature around school

Based on my reflections throughout the project and, in particular my consideration of *why* the project was less successful than hoped in the initial cycle of research and action, I also made the following recommendations to enhance the *processes* of the project:

- The Deputy Head and working party should seek to increase the participation of the Headteacher, in order to increase the project's power and prioritisation in school.
- The Deputy Head and working party should meet to reinvigorate the action plan, based on the content of the evaluation data.
- The action plan should be revised to have fewer targets (prioritised from those recommended above), and more specific targets with tangible outcomes.
- The action plan should plan for and implement more 'short-term wins' in relation to the project's aims.
- The DH should continue to lead the working party with regular meetings to check the implementation of agreed actions.
- The Deputy Head and working group should actively consider how to reduce identified restraining forces (Figure 3).
- The Deputy Head and working group should provide more on-going feedback to the whole staff group.
- After an agreed time (suggested 6months-1year), further evaluation data could be gathered using similar measures and information gathering approaches (i.e. individual questionnaires and focus groups)

10.2 Reflections on the RADIO model and implications for EPs

Despite the disappointing evaluation findings, the current project highlights some important issues and implications for EPs, particularly as many services are now operating within a 'traded' context with high accountability to schools. In applying the RADIO model as an overarching framework to this project, I now critically appraise its many advantages and propose suggestions for updating it in order to present a realistic, contemporary and useful framework.

Overall, I consider that the current project's 'downfall' occurred at the action planning and implementation stages (RADIO Stages 10-11). The project's 'soft complexity' (Paton and McCalman, 2008) led to subjective and ill-defined objectives in the action planning stages, which made implementation difficult: evaluation data suggest that outcomes were not tangible to staff. In addition, despite exploring possible threats to successful implementation of the action plan (force field analysis, Figure 3), it was difficult to identify specific factors that may reduce these threats and therefore no tangible efforts were made to address them. This highlights important potential modifications to the RADIO model. My recommendations are twofold: (i) firstly, I propose that Stage 3 of the model 'clarifying organisational and cultural issues' should be re-worded to encompass the need to *address* these issues; and (ii) I propose that consideration of organisational and cultural issues ought to be repeated during the action planning and implementation stages, such as conducting a force field analysis. Furthermore, the literature suggests planning for evaluation during Stage 6 (negotiating initial data gathering), which proved beneficial in the current study as pre- and post- implementation measures were possible. This could also be added to the RADIO model to improve its usefulness to EPs when planning organisational development work in schools.

In Chapter 4, I reflected upon the missing stage of 'data analysis by the EP' following data collection. Upon further reflection, I consider that 'data analysis by the EP' is also missing from the evaluation stage of the model. Furthermore, having argued the case for the importance of feedback in action research, I suggest that formative feedback following evaluation has paramount importance, but is currently overlooked by the RADIO model. Arising from the unsatisfactory evaluation data of the current project, I also recommend that the action research *cycle* should be clearly explained at the outset, particularly in the context of a traded Educational Psychology Service, in which accountability and expectations of schools are high.

Based on my reflections throughout Chapter 4 and 5, I propose that the RADIO model (Timmins et al, 2006; Figure 1), could be updated as discussed, in order to aid EPs in conducting successful action research in schools, and in order to provide a realistic framework to school stakeholders when negotiating organisational development work. These changes could support EPs and schools to overcome some of the challenges that were experienced throughout this project.

Finally, I conclude that there is a role for EPs in conducting action research with schools, but that the process is not always straightforward. I suggest that the application of frameworks such as the RADIO model (Timmins et al, 2006) and MacDonald and O'Hara's (1998) '10-element map' of mental health, are useful in structuring project work. I caution that EPs should set realistic expectations with schools and highlight the cyclical process of action research, in order to avoid disappointment or disillusionment from schools, particularly if, as in the current study, the first cycle of action does not result in positive evaluation findings.

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APPENDIX 1: Agenda for feedback and action planning meeting

Staff Well-being Project

Agenda

1. Welcome and introductions (5 min)
    a. Thanks for attendance
    b. Purpose of the group
    c. Structure of this session

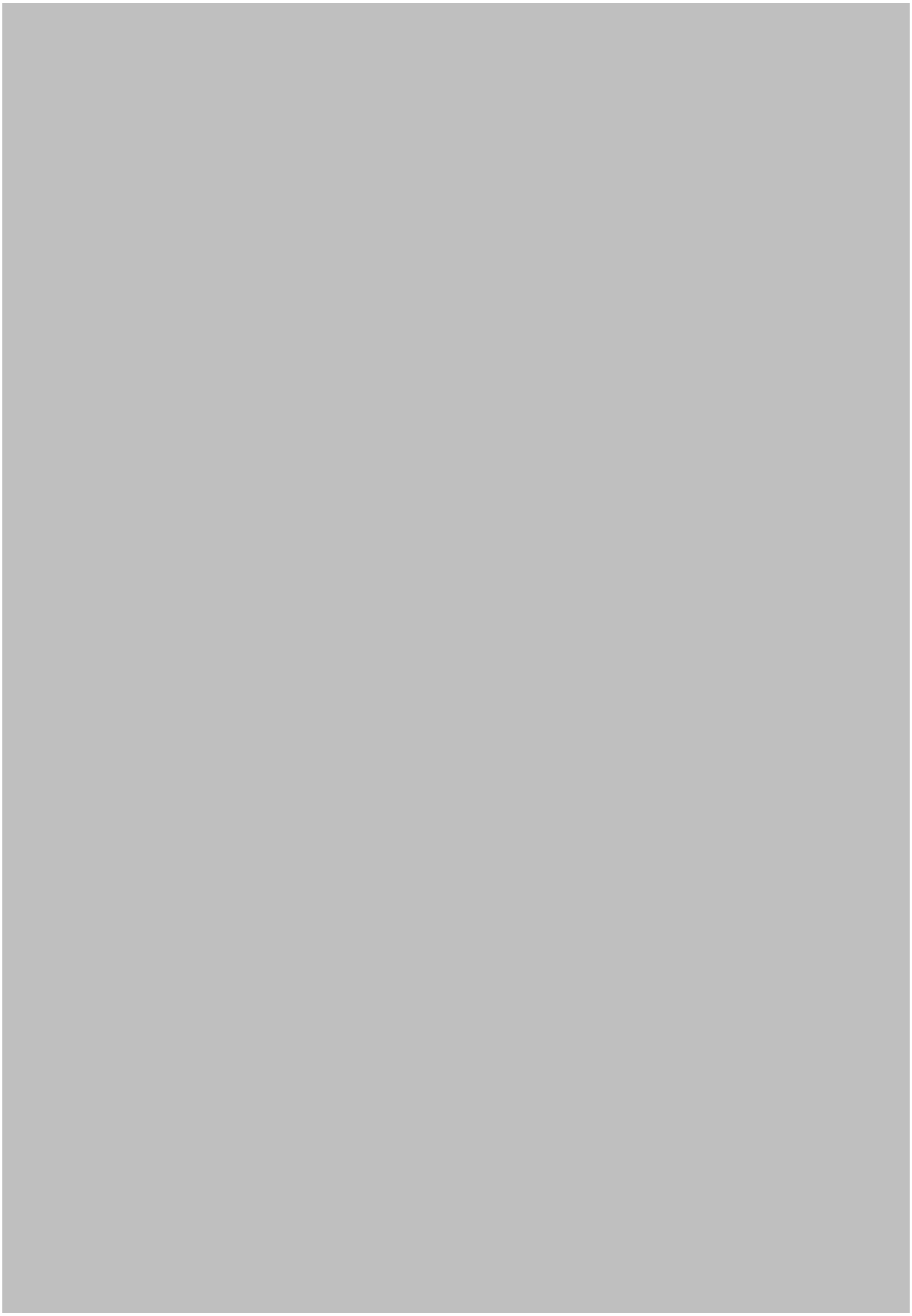
2. Feedback about the current situation (10 min)
    - Firstly, ask for feedback on 10 element map
    - Quantitative data
    - Qualitative data

3. Introduction to action planning (10 min)
    - Part 1: Agreeing the key areas (discuss in groups then share)
    - Part 2: Explain how to use action planning sheets

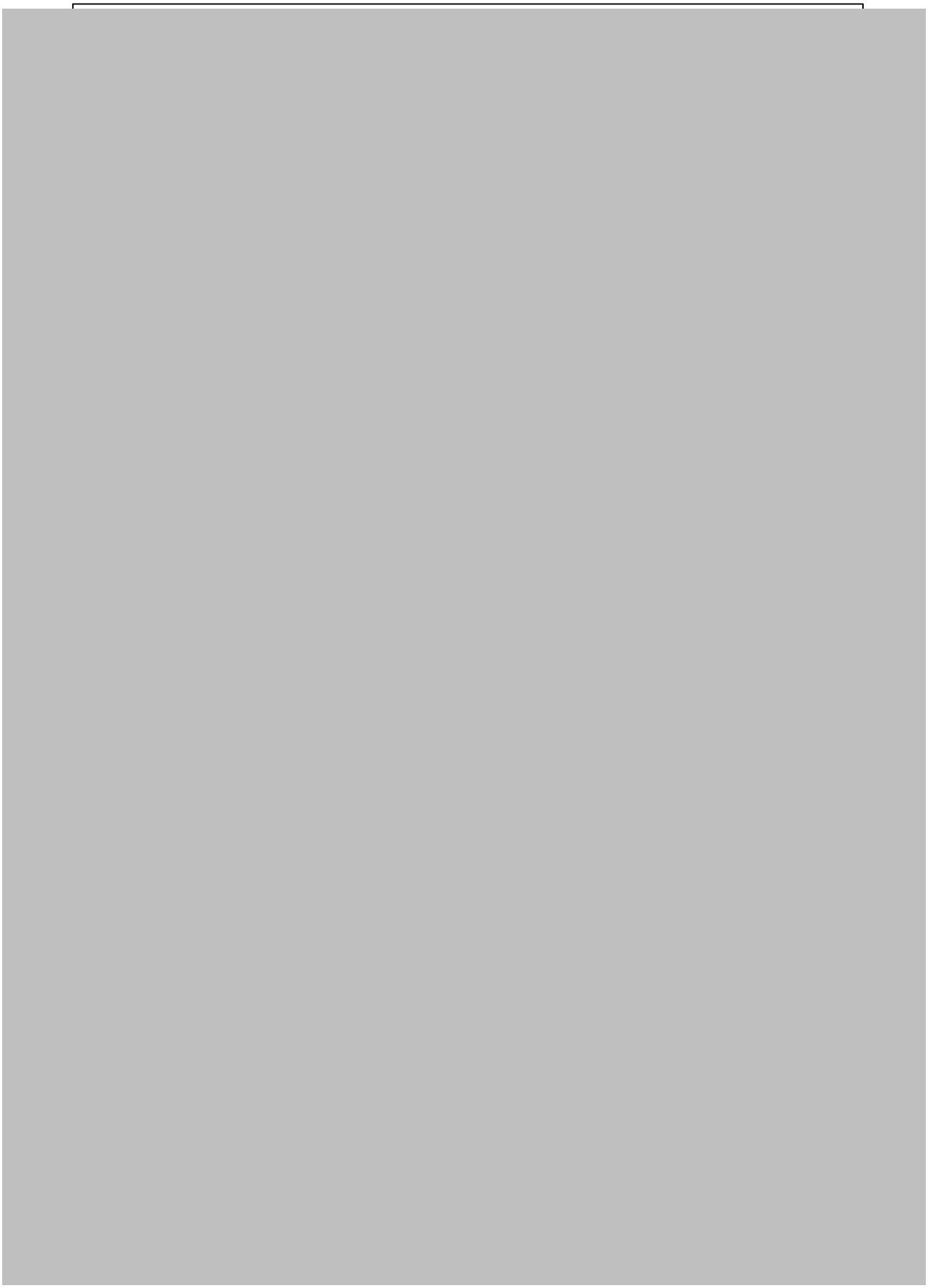
4. Group work: action planning (20 min)

5. Group feedback and agreeing next steps (15 min)

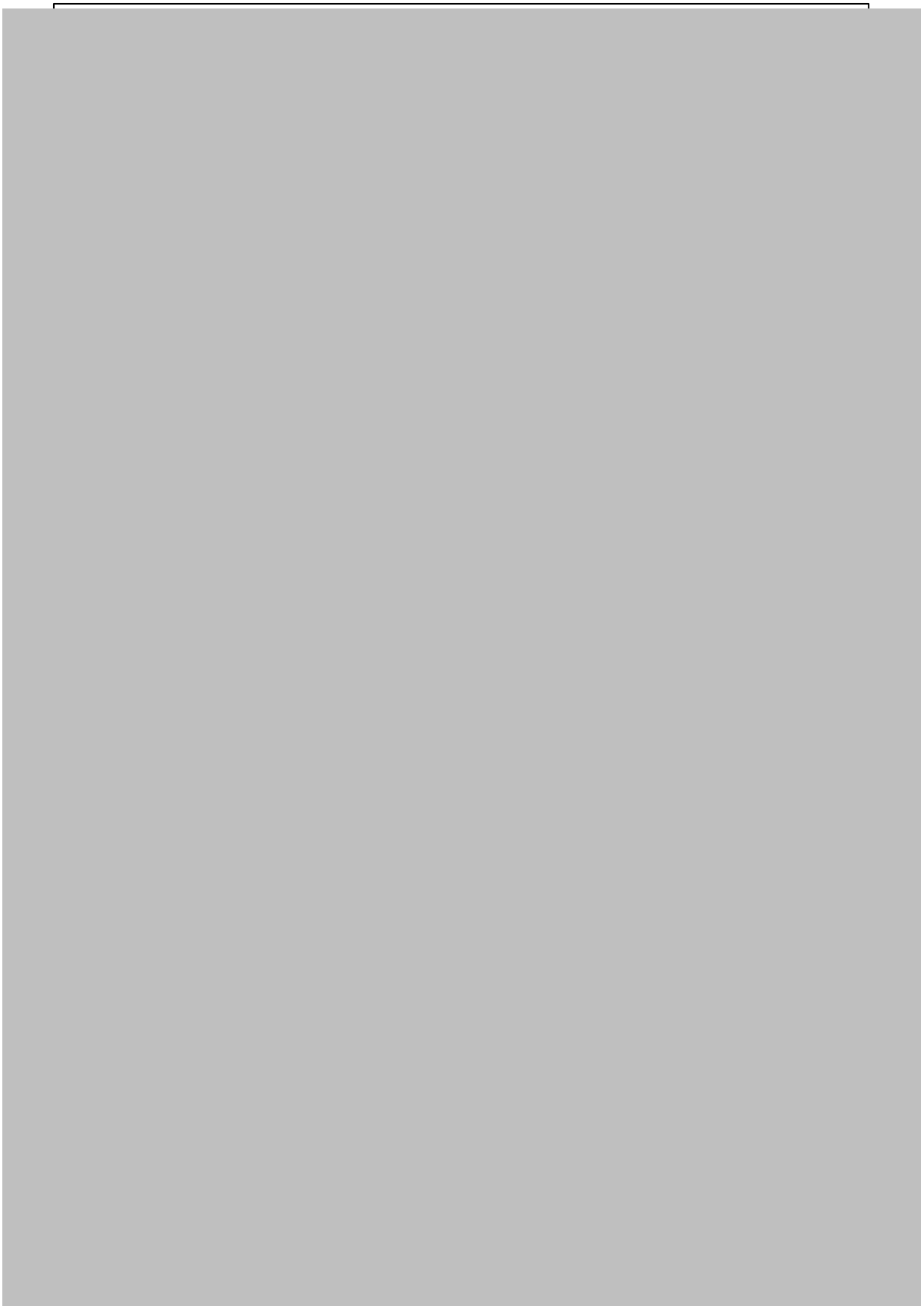
APPENDIX 2: Completed action plan, annotated with implementation review notes



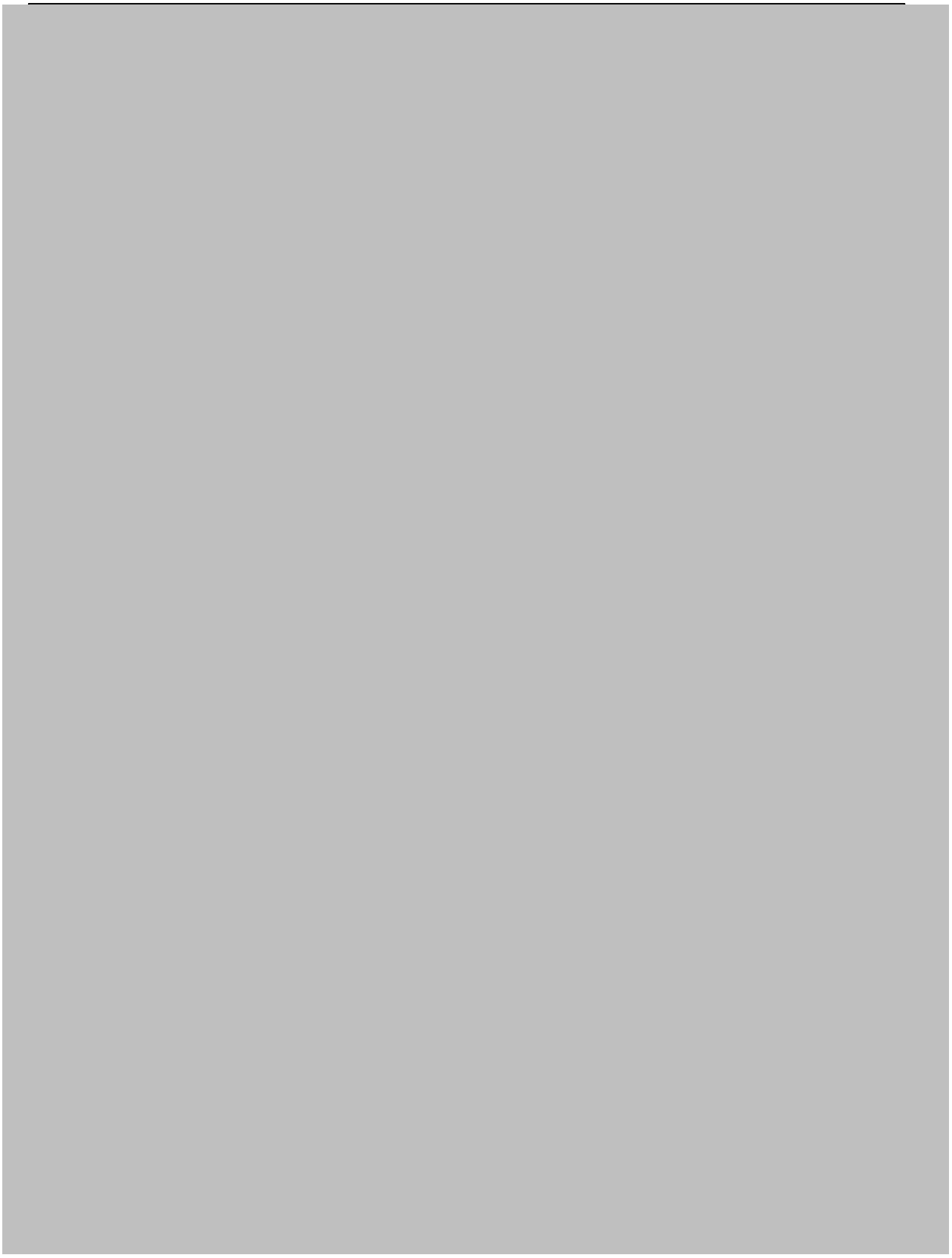
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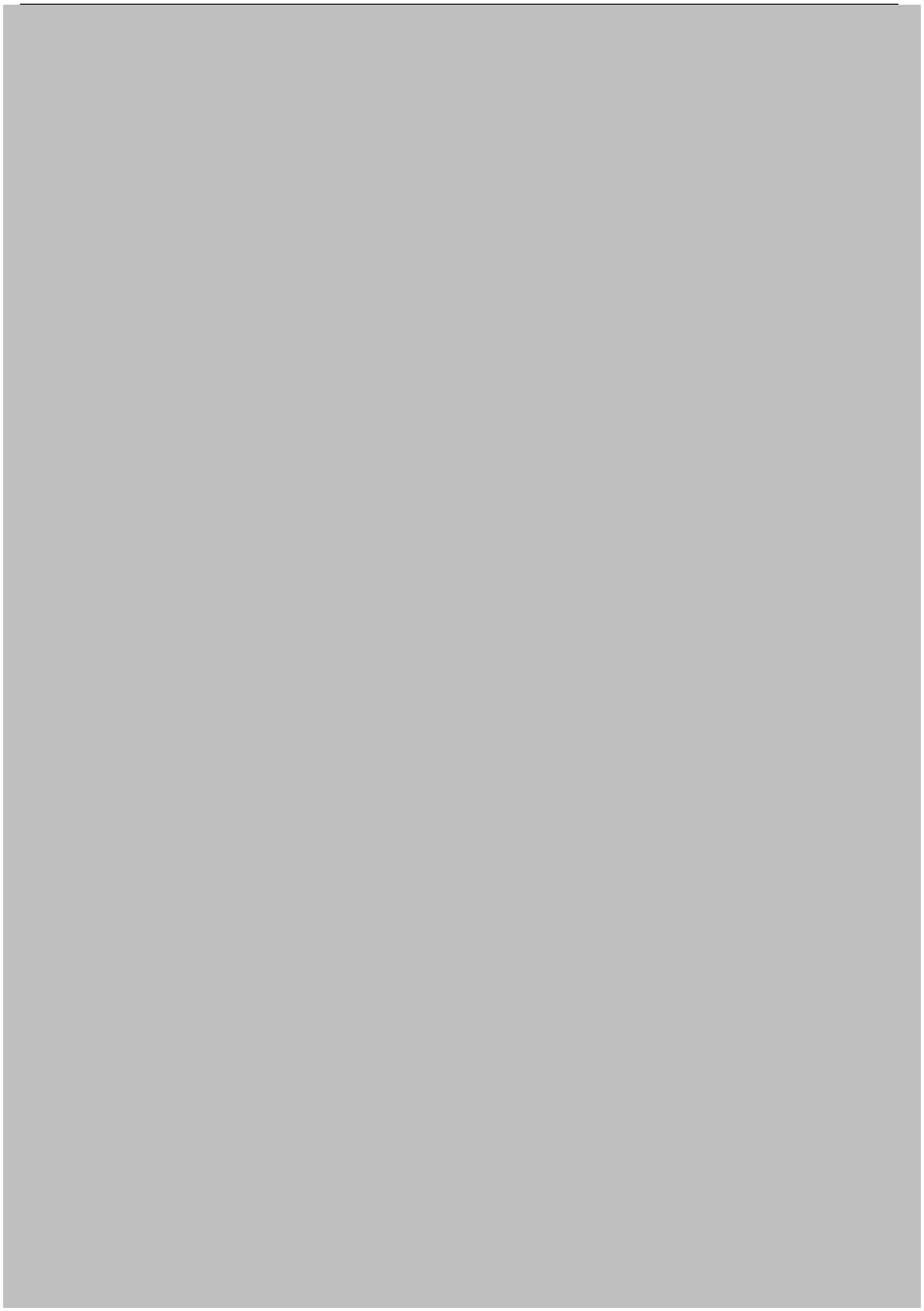
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APPENDIX 3: Individual questionnaire for evaluation

Staff Well-being Project Evaluation

How is staff well-being in April 2015?

Q1: Now, in April 2015, how would you rate staff well-being?
(Please answer the five questions in the figure below, giving a score out of 10)



Q2: Did you take part in the staff INSET workshop last year on 28.4.14? *(please circle)*

Yes No Don't know

Q3: Overall, do you think staff well-being has improved since April last year? (please circle/tick)

5	It's improved a lot
4	It's improved somewhat
3	It's still the same
2	It's got a bit worse
1	It's got a lot worse
N/a	I wasn't here so I can't compare!

Q4: Do you have any comments about what is going well?

Q5: Do you have any comments about what is not going well?

Q6: Do you have any ideas to further promote positive well-being at school?

Thank you ☺