Speech and language therapy in practice: a critical realist account of how and why speech and language therapists in community settings in Scotland have changed their intervention for children with speech sound disorders

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Wheels within wheels
In a spiral array
A pattern so grand
And complex
Time after time
We lose sight of the way
Our causes can't see
Their effects

Neil Peart, Natural Science

Abstract

Healthcare professionals such as speech and language therapists are expected to change their practice throughout their career. However, from a practice perspective, there is a lack of knowledge around what practice change is, what it really takes, and why there are different trajectories. Consequently, therapists, managers and commissioners lack empirical evidence on which to base decisions about enabling practice change. In addition, intervention researchers lack basic sociological research around implementation that could inform their research designs, reporting and impact.

This case-based sociological inquiry, underpinned by critical realist assumptions, was designed to address this knowledge gap. It includes a two-stage qualitative synthesis of 53 (then 16) studies where speech and language therapists explained the work of their practice in depth, and a primary qualitative study focused on one professional jurisdiction, children with speech sound difficulties (SSD). Forty two speech and language therapists from three NHS areas and independent practice in Scotland participated in individual interviews or self-organised pairs or focus groups to discuss in depth how and why they had changed their practice with these children. A variety of comparative methods were used to detail, understand and explain this particular aspect of the social world.

The resulting theory of SSD practice change comprises six configured cases of practice change (Transforming; Redistributing; Venturing; Personalising; Delegating; Refining) emerging from an evolving and modifiable practice context. The work that had happened across four key aspects of this context (Intervention; Candidacy; Caseload; Service) explained what made each case possible, and how practice had come to be one way rather than another.

Among its practical applications, the theory could help services plan more realistic practice change. In addition, the inductively developed layered model of SSD intervention change has the potential to contribute to speech and language therapy education as well as methodological discussions around complex interventions.

Acknowledgements

Anne smiled and said,

'My idea of good company, Mr Elliot, is the company of clever, well-informed people, who have a great deal of conversation; that is what I call good company.'

Jane Austen, Persuasion

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Summary of thesis

Section I (What I Did)

Chapter 1 frames the <u>empirical problem</u>: the gap between expectations of practice change in the helping professions and knowledge - from a practice perspective - of what practice change is, what it really takes, and why there are different trajectories of change. To investigate this, I make the case for basic sociological research using an implementation-practice-profession lens and the research question, 'How and why have speech and language therapists changed their practice with children with speech sound disorders/difficulties (SSD)?'

Chapter 2 makes explicit the <u>methodology and design</u> chosen to answer the research question. The set of methodological ideas includes critical realism as a meta-theoretical umbrella, and a three-part theoretical structure (social ontology; explanatory frameworks; practical social theory). The design is a case-based sociological inquiry with three components (a primary qualitative study; sensitising theories; a qualitative synthesis).

Chapter 3 explores the contribution of the <u>qualitative synthesis</u> component, a hybrid of realist sampling and meta-ethnography, using the research question, 'How have speech and language therapists explained the work of their practice in in-depth qualitative studies?' This provides learning, context and theoretical sensitisation for the primary qualitative study, and enables ideas around practice change dimensions and platforms to be developed and fed into the practical social theory.

Chapter 4 discusses <u>methods</u> for the <u>primary qualitative study</u> component. These are used to set the research scene (realist sampling; recruiting; thinking ethically), produce the primary data (interviewing; transcribing; anonymising) and generate the practical social theory (through questioning, coding, modelling, narrating, and writing). I also describe the study sample of 42 participants from three NHS areas and private practice in Scotland, and illustrate my approach to validity.

Section II (What I Found)

Chapter 5 summarises what I found in the form of a practical social theory of SSD practice change. Six configured cases of practice change (Transforming; Redistributing; Venturing; Personalising; Delegating; Refining) emerged from work in and across an evolving and modifiable practice context. These different trajectories were made possible over time by key conjunctures of mechanisms across Intervention, Candidacy, Caseload and Service aspects of the practice context.

Chapter 6 unpacks the Intervention aspect of the practice context with reference to a 10-element model. Derived inductively, it represents elements of specialist SSD intervention that can change, and the different types of work involved. I explore how these changeable elements and layers (theoretical; logistical; processual; observable) of intervention help to make sense of eclecticism and implementation challenges.

Chapter 7 disentangles judgements around Candidacy for starting, continuing and ending speech and language therapy for SSD. Specialist knowledge was needed to judge the child's impairment and intelligibility, and the relevance of interventions. A therapeutic sensibility was needed to judge the personal impact of the SSD, motivation to do something about it, and risk. I illustrate how applying these apparently similar judgements with more or less depth created key differences for practice change.

Chapter 8 investigates the consequences of the Caseload aspect of the practice context for the trajectory of change. Made up of individual children but also a whole, caseloads belonged both to a therapist and to the service. I show how different platforms for practice change were created by variation in how challenges of size, composition, time on caseload, and distribution of caseload work were addressed.

Chapter 9 assesses similarities and differences in the Service aspect of the practice context. To help explain why practice change went in one direction rather than another, I examine the key dimensions of organisational model,

what the service had invested in SSD, service expectations, and what kind of practice was, or was not, routinely possible.

Chapter 10 configures the six cases of practice change, showing how the Intervention, Candidacy, Caseload and Service aspects of the practice context helped to make them possible. To explain further how and why participating speech and language therapists changed their practice for children with SSD, I discuss each case and posit differentiating mechanisms for its emergence.

Section III (What this Means)

Chapter 11 relates what I found to previous scholarship, and translates it into six practical propositions for using this research. These relate to planning SSD practice change, mapping intervention complexity, managing uncertainty, student placements, using comparison, and protecting applied linguistic expertise. I then consider the validity and limits of the thesis, reflecting on its contribution to knowledge and what I have still to do. After considering possibilities for moving this research on, I conclude by reflecting on the value of investigating the mundane detail of how people get things done.

Section I: What I Did

1 Framing the question

1.1 Why 'practice change'?

Any thesis has at its heart an intellectual curiosity, and mine is the how and why of practice change in the helping professions. What is the nature of their work? Why do they do it this way and not that way? How come what they do here differs from what they do there? How did this practice stick, while that one fell away? Why was this change easy but that one difficult?

Questions about how practice *can* be changed in routine settings matter because healthcare professionals are expected to change practice throughout their career. The ethical imperative may include ensuring research findings benefit clients (Solomon 2010), addressing sub-optimal, unnecessary and harmful care (Grol and Grimshaw 2003), and improving service quality, for example by making it more person-centred, effective, or safe (The Scottish Government 2010). The catalyst for change can come from many sources, including clinical and personal experience, research findings, service or policy initiatives, new legal, regulatory or professional standards and guidelines, and changes in client expectations.

There are, however, persistent gaps between expectations of practice change and the reality, sometimes expressed as time lags of well over a decade (Slote Morris et al. 2011; Balas and Boren 2000). Elucidating the nature of such gaps, and effective ways to address them, is a growing research priority (Eccles et al. 2009), but methodological challenges arise in the absence of clear evidence about where practice is and where it ought to be and whose perspectives should count. Moreover, the practical challenges of meeting such expectations in an era of constrained public sector resources cannot be ignored.

This thesis borrows the social science premise that practice change takes individual and collective *work*, and that explicating this work may help to explain gaps between expectations and reality (May et al. 2009). It applies the idea by investigating how practice in a specific field of healthcare has - and has not - changed over time. Using speech and language therapists' work with children

with speech sound disorders (SSD) as an exemplar, it explores from their perspective:

    i.   What is 'practice change' in relation to children with SSD?

    ii.   What does it really take to change practice?

    iii.   Why are there different trajectories of practice change?

My practical purpose is to make the complex work of practice change visible and explicit in a way that will resonate with speech and language therapists, managers and researchers. By grounding this research in routine clinical practice rather than a research context, I hope the findings will help them to acknowledge, anticipate and address pressing implementation challenges for the profession.

This chapter frames the research problem and question. Section 1.2 introduces three academic lenses on the work of practice change - implementation science, practice theory, and sociology of professions and work - and shows how they intersect to provide a path for this thesis. Section 1.3 makes the case for using the speech and language therapy profession as an exemplar, with section 1.4 narrowing the frame to the jurisdiction of children with speech sound difficulties. To enable this thesis to build on what is already known about this topic, section 1.5 reviews the literature around what speech and language therapists do with such children. Finally, having framed the problem of practice change and identified the space for this basic sociological research, section 1.6 poses the research question for investigating it: how and why have speech and language therapists changed their practice with children with SSD?

1.2 How have scholars viewed the work of practice change?

From their different perspectives and academic traditions, a cornucopia of scholars has been concerned with explicating the collective work of practice change. In contemporary literature, three lenses stand out: implementation science, practice theory and sociological understandings of professions and work.

Implementation science is closely aligned with applied health services research. Broadly speaking, an implementation lens views the work of practice change as a staged process of implementing (or de-implementing) an evidence-based intervention, innovation, programme or way of working, with a range of factors acting as facilitators or barriers in different settings (Moullin et al. 2015).

Practice theory is an umbrella term for theories and methods commonly used in studies of organisations, education and learning. A practice lens is also processual but, rather than charting the journey of an intervention, sees the work of practice change as assemblages of people (bodies), tools and situations constantly making and re-making the world (Nicolini 2012).

Sociological understandings of professions and work give priority to explicating the social processes through which people's labour becomes differentially valued and elites (including professions) seek to defend and advance their status. As what constitutes work is socially constructed, any classification inevitably renders different types of effort more or less visible (Bowker and Star 2000).

Although they share a theoretical and empirical curiosity about the work of practice change, and have considerable overlap, for someone new to academia these three lenses appear largely to inhabit separate research spaces. In the following sections, I will explore how they intersect to frame a promising path for this thesis.

1.2.1 An implementation lens

Implementation science uses systematic research methods and theory to explore how the uptake of evidence in clinical practice could be improved. Rather than establishing the effectiveness of an intervention, practice or programme *per se*, the aim is to investigate systematically the effectiveness of its implementation or de-implementation, and thus to provide generalisable, evidence-based strategies (Eccles et al. 2009). While this is not a new idea, the research discipline is young (Sobo et al. 2008). Its influence has been growing since a landmark review of UK health research funding highlighted the need to address a lack of NHS capacity for implementing new interventions (Cooksey 2006).

Implementation science is complementary to intervention science, where healthcare interventions are viewed as complex with multiple interacting components (Craig et al. 2008). From a systematic review of implementation frameworks, Moullin et al. (2015) identified core stages when using an implementation science lens: developing an intervention, then communicating to raise awareness of it, exploring and installing (adopting) it, implementing it, and sustaining it.

The natural phenomenon of adaptation, where people work to improve the fit between intervention and context, bridges intervention and implementation science. Even where an intervention is well specified and evidence is compelling, complex interventions do not work of themselves but in how they are adapted as they pass through and are shaped by the active (and possibly contradictory) reasoning and reactions of users and recipients (Pawson 2006). Adaptations may relate to service setting, the target audience, mode of delivery, or culture (Chambers and Norton 2016). Fidelity to the prototype refers to the degree of adaptation or variation which can be tolerated throughout the stages of implementation, procedurally and qualitatively, before effectiveness is compromised (Kaderavek and Justice 2010).

Through an implementation lens, the level and complexity of work required for implementation is therefore seen to derive from the nature of a proven intervention in interaction with the people and contexts where it is introduced. As a consequence, implementation studies frequently identify barriers and facilitators, but these may provide insufficient detail to enable transfer from one context to another (Lau et al. 2016; Mair et al. 2012). For example, for their qualitative research in general medical practice, Checkland et al. (2007) purposefully selected innovative medical practices with apparent similarities. Detailed comparative case studies showed different approaches would have been needed to facilitate implementation of a policy framework because:

> the 'barriers' reported as preventing implementation are less important than the context and underlying social relations that have given rise to them. (Checkland et al. 2007, p.100)

An implementation lens recognises that understanding the hows and whys of implementation work may require theoretical exploration of human behaviour

change or action at multiple levels, such as the system, community, organisation, individual and policy (Tabak et al. 2012). As a consequence, implementation science draws on and has spawned a range of psychological, sociological and organisational models, frameworks and theories (Moullin et al. 2015; Nilsen 2015; Tabak et al. 2012). Nilsen's taxonomy helpfully differentiates those which seek to guide research into practice, those which try to understand or explain implementation outcomes, and those intended to evaluate implementation (Nilsen 2015). Those most relevant to the work of practice change are focused on understanding and explaining implementation outcomes. Nilsen subdivides these into integrative determinant frameworks, classic change theories and middle-range theories.

In practice, each of these subtypes can help with middle-range structure of an inquiry. Middle-range theories are neither too remote nor too particular in relation to the empirical world (Merton 1967), are intended for useful application to empirical problems, and are generally a product of academic research (Davidoff et al. 2015). They differ from the small programme theories of change which invite improvers to specify outcomes, measures and activities of specific practical projects (Lowenthal 2016; Davidoff et al. 2015). Using Nilsen's taxonomy (2015), two determinant frameworks, one classic theory and one implementation theory have gained particular traction in the implementation science field for middle-range explication of the work of practice change in different contexts: PARiHS (Promoting Action on Research Implementation in Health Services), the Theoretical Domains Framework, Diffusion of Innovations, and Normalisation Process Theory.

1.2.1.1 PARiHS

The PARiHS framework of implementation work grew from efforts by researchers to help clinicians introduce new ideas and guidelines to improve their practice. It posits that implementation success is a consequence of interaction between evidence (negotiated from research, clinical experience, patient preferences, and routine information), context (including culture and leadership) and facilitation, each of which is open to manipulation (Rycroft-Malone 2010; Kitson et al. 2008). PARiHS frames implementation work as complex, dynamic and situated (Rycroft-Malone et al. 2013). McCullough et al.

(2015), for example, used PARiHS in an ethnographic case study to show how the interplay between particular sub-elements of context (teamwork, communication and leadership) interacted with level of belief in the evidence to produce different patterns of uptake of a quality improvement intervention across five sites.

1.2.1.2 Theoretical Domains Framework

The Theoretical Domains Framework is based on the premise that, as implementation depends on human behaviour, the work of implementation is a process of behaviour change (Michie et al. 2005). It was developed then validated and refined through a robust expert consensus process in an effort to define key explanatory domains and their component constructs from the plethora of psychological behaviour change theories (Cane et al. 2012; Michie et al. 2005). The fourteen domains are: knowledge; skills; social / professional role and identity; beliefs about capabilities; optimism; beliefs about consequences; reinforcement; intentions; goals; memory, attention and decision processes; environmental context and resources; social influences; emotion; and behavioural regulation (Cane et al. 2012). These domains can be used to identify barriers and facilitators to collective healthcare professional behaviour change in different contexts. For example, by holding focus groups of staff at eight acute stroke units, Lynch et al. (2017) were able to use the Theoretical Domains Framework to interpret different patterns of assessment for rehabilitation after stroke.

1.2.1.3 Diffusion of Innovations

Sociologist Everett Rogers' seminal book on Diffusion of Innovations was first published in 1962. The idea of diffusion of innovations as a general social change process emerged when he compared his experience researching rural agriculture with papers on diffusion from a variety of unrelated fields (Rogers 2003). Rogers continued to update, critique and refine his theory in light of social changes, and argued for more studies of consequences: "the changes that occur [in] an individual or a social system as a result of the adoption or rejection of an innovation" (Rogers 2003, p.436). However, the main elements endure - that a perceived innovation is communicated over time among members of a social system - and are at the centre of an implementation lens.

While classic change theories have been applied to empirical implementation studies at the individual level, this is less evident at collective and organisational levels (Nilsen 2015).

1.2.1.4 Normalisation Process Theory

Normalisation Process Theory has arguably done most to establish the idea that accomplishing implementation takes individual and collective work, as its core dimensions are sense-making work (Coherence), relationship work (Cognitive Participation), enacting work (Collective Action) and appraisal work (Reflexive Monitoring) (Mair et al. 2012). The theory developed out of secondary analysis of qualitative data from healthcare settings (May et al. 2009) in an effort to explain agency in action in context - in other words, how to account for the things people actually do (May 2013).

The main architect of Normalisation Process Theory, Carl May, developed it to fill a sociological gap between theories that focused on the attributes of organisations and policy environments, and those based on psychological individualism. By focusing on processes - and collective action as it informs these processes in different contexts - he hoped to enable prospective decision-making as well as retrospective understanding of implementation issues (May 2013). An early iteration of Normalisation Process Theory was used to interpret a secondary analysis of qualitative data in reports of studies of a popular speech and language therapy intervention programme for children with language delay (James 2011). This produced new understanding of the internal components of the programme which had helped it become embedded in everyday practice. In addition, the analysis process identified limits on the programme's distribution among other professionals, which may be relevant to implementation of future interventions.

1.2.1.5 Working on context to make implementation possible

As the field of implementation science matures, focus has shifted from the work of implementing an intervention to the work of modifying its context to make implementation possible. The challenge for specifying these modifications is that contextual complexities are normal and dynamic conditions of the everyday

practice where new interventions are intended to be used (Coles et al. 2017; Pfadenhauer et al. 2017; May et al. 2016).

Specifying context for implementation has typically followed an ecological logic. Through a systematic review of implementation frameworks, Moullin et al. (2015) classified the intervention-people-context interaction into domains of the innovation, individuals, organisation, local environment, and external system. Pfadenhauer et al. (2017) constructed a more comprehensive Context and Implementation of Complex Interventions framework through a rigorous process including a pragmatic utility concept analysis of the terms. The framework comprises three dimensions which interact with each other and the intervention: context, implementation and setting. Setting relates to the particular location, while context has seven domains (geographical, epidemiological, socio-cultural, socio-economic, ethical, legal, political) operating at micro, meso and / or macro levels.

Interventions which are entrenched in historical, economic, political and social contexts may be particularly difficult for healthcare professionals to recognise and modify. Ian Graham traced the history of routine episiotomy in obstetrics as a prophylactic measure (Graham 1997) and radical mastectomy as an "unvarying response" to breast disease (Montini and Graham 2015, p.2) to show that a systems level approach was necessary to understand why these interventions persisted long after strong evidence against their use emerged.

In their forthcoming realist review on the influence of context on improvement interventions, Coles et al. (2017) will explore not just which contextual factors matter in different settings, but how, why, when and for whom they are important. 'For whom' could be key; from a systematic review of 70 reviews into achieving change in primary care, Lau et al.'s (2016) four-level ecological framework describing key influences on implementation had the intervention nested not only in the organisation and external context, but most closely in a *professional* layer encompassing themes of professional role, philosophy of care, attitudes to change, and competency.

This close relationship between an intervention and its professional context also emerges from a complexity spectrum relating to 14 characteristics identified

through an in-depth multiple case study exploring the role of context in randomised controlled trials of complex healthcare interventions (Wells et al. 2012). Most definitions at the 'highly complex' end would apply to most healthcare professionals' practice (e.g. several components within intervention with low confidence around the 'active ingredient'; dependent on client's participation over time, professional judgement / skill, and human interaction; implications for the service as a whole; important but ambiguous outcomes).

Normalisation Process Theory has recently been extended to take more account of the everyday reality of context and complexity influencing practice, and how this plays out over time (May et al. 2016). Implementation is seen to involve work to restructure relationships between people, intervention components and elements of context, with these relationships coupled on a spectrum from loose to tight (May et al. 2016). Within these couplings, intervention components have more or less plasticity to be moulded, and contexts have more or less elasticity to accommodate new interventions (May et al. 2016). All the while, to maintain a service while implementation unfolds, healthcare professionals:

> need to work to sustain an orderly pattern of social interactions and relations and a predictable flow of events in the face of complexity (May et al. 2016, p.7)

To enable healthcare professionals to identify contextual aspects which are open to change, these insights point towards an implementation lens not only focused on the intervention but zoomed out sufficiently to capture the immediate professional activity around it. This pragmatic approach to the concept of context echoes the PARiHS priority that "the context of practice needs to be understood and challenged in implementation programmes" (McCormack et al. 2001, p.101).

From the rich and growing field of implementation science, we have learnt that implementation work applies to the context for the intervention as much as to the intervention itself, and that the immediate professional activity around an intervention may provide clues about where people can potentially work to modify the context. To understand how this dual work might best be explicated,

and how implementation can be studied even in the absence of a proven intervention object, a turn to practice is warranted.

1.2.2 A practice lens

Like implementation science, practice theory is not one entity, but a vast collection of ideas for framing and investigating empirical problems. Although the concept has a long history in the philosophy of science, a 'practice turn' in sociology and across a range of disciplines in recent decades has been characterised by one of its chief proponents as:

> a loose, but nevertheless definable movement of thought that is unified around the idea that the field of practices is the place to investigate such phenomena as agency, knowledge, language, ethics, power and science (Schatzki 2001, p.22)

Whether making a sandwich, playing the piano, putting out a fire or doing speech and language therapy, a practice lens sees these 'practices' as the nexus of continuity, renewal, and emergent change. The work of practice change is viewed as part and parcel of the work of practice because practice is an ongoing process of becoming through some type of ensemble, entanglement or topology of people (bodies), tools and situations.

While practice theorists differ in exactly how they conceptualise humans in a material world, with consequences for empirical investigations, a review of these differences is beyond the purpose of this thesis. Of relevance is that the same theory may be operationalised and reported through an implementation or a practice lens; in a systematic review of qualitative studies to explicate the nursing work needed to implement clinical practice guidelines, Normalisation Process Theory was positioned as "a robust practice theory" (May et al. 2014). The same scholar may also be involved in both implementation and practice studies; Brendan McCormack was key to PARiHS, but has also developed the field of emancipatory practice development (Manley and McCormack 2003).

As a tactic for research drawing on practice theories, organisational sociologist Davide Nicolini argued for an eclectic toolkit approach, both in the interests of good social science and to do justice to practice's multidimensional nature (Nicolini 2012, p.215). Similarly, but from a professional learning perspective,

Reich and Hager (2014) recommended different emphases of practice theory be seen as complementary rather than competing resources for doing practice research. Having problematised the concept of 'practice' to open up new ways of understanding how professionals learn and how practices persist and change, they identified six empirically supported overlapping threads for practice investigations: practices as knowing-in-practice (knowing how to do through the doing); the sociomateriality of practice; practices as embodied; practice as relational; practices as existing and evolving in historical and social contexts; and practices as emergent (Reich and Hager 2014).

In addition to Normalisation Process Theory, a practice lens offers a number of tools to advance this thesis: Practice and Practice Architectures theory, a focus on mundane detail, and a rationale for following the practice.

1.2.2.1 Practice and Practice Architectures

Educational theorist Stephen Kemmis's middle-range practice theory, Practice and Practice Architectures, aims to elucidate the collective work of practice change in particular contexts of action. As "practice has a number of extra-individual features", it follows that "neither practice itself nor the process of changing practice can be adequately understood without reference to these" (Kemmis 2011 pp.140-141). Practitioners are understood as architects rather than technicians; they participate in projects in order to support individuals to live well, while at the same time collectively building a world worth living in (Kemmis 2012). Distinctive sayings, doings and relatings of practice are viewed as hanging together and made possible by an invisible architecture located in corresponding semantic (meaning of language) space, physical space-time and social space (Kemmis et al. 2014). Practices and their particular contexts (architecture) are therefore viewed as tightly related but distinguishable. Depending on the circumstances, it may be more or less possible to change the practice without also having to work on its architecture.

1.2.2.2 The case for mundane detail

A practice lens clearly calls for attention to the mundane detail of practice in all its complexity and uncertainty, making routine profession-specific practice a legitimate focus. Cristancho et al. (2015), for example, asked surgeons both to

discuss clinical judgements in challenging and evolving situations and to sketch rich pictures of these moments. This brought contextual influences to the fore, addressed surgeons' tendencies to simplify description and focus on procedures, and helped to overcome difficulties in making tacit knowledge explicit (Cristancho et al. 2015). Armstrong and Ogden (2006) asked GPs to describe their usual prescribing practice for depression and dyspepsia (purposively selected to contrast a relatively stable area of treatment and a more evolving one) and to recall times when they had started prescribing new treatments. They detected subtle social mechanisms which had helped the GPs to change their prescribing practice in spite of other subtle social mechanisms which constrained them from doing so.

1.2.2.3 Following the practice

From ethnographic research in primary care and hospitals, Gabbay and le May coined the term 'mindlines' (guidelines-in-the-head) to account for the cumulative knowledge-in-practice-in-context that enabled GPs to make rapid, complex decisions in demanding circumstances (Gabbay 2016; Gabbay and le May 2004). The diverse and sometimes contradictory influences on clinical decisions came from expectations across clinical, management, public health and professional self-management domains (Gabbay 2016). This chimes with Silvia Gherardi's observation that practices are nested:

> practices rest on other practices: that is, they are interconnected and their interconnection makes it possible to shift the analysis from a practice to a field of practices which contains it, and vice versa (Gherardi 2012, p.155)

A practice lens therefore follows a practice and its trajectory (what Gabbay and le May refer to as working "with the grain of practice" (2011, p.198)), but zooms out to surrounding practices to investigate how "configurations, assemblages, bundles, and confederations of practices" are kept together (Nicolini 2012, p.230). The complexity can be managed by isolating any practice which may have an anchoring, controlling, constraining or organising role in relation to other practices (Gherardi 2012, p.156).

To explicate the work of practice change, an implementation lens drew attention to the importance of work on both intervention and its contexts, in particular the immediate professional activity. A practice lens has allowed us to build on these

insights. Close attention to the trajectory of practice in the context of other practices - and applying ideas of practice architecture, anchoring roles, surrounding domains and configurations - intersects with the idea of interrogating interventions and their contexts. It leads us to ask, what particular practices surround and support intervention practices, and what work does it take to change *them*? As a practice lens also reinforces the suggestion from an implementation lens that profession plays a vital role in the work of practice change, a focus on profession is merited.

1.2.3 A profession lens

To understand how a profession lens may further explicate the work of practice change, sociologist Andrew Abbott's notions of contested jurisdictions and interdependent systems are instructive. In his seminal Essay on the Division of Expert Labour (1988), Abbott posited that jurisdictions are "the central phenomenon of professional life" linking "a profession and its work" (Abbott 1988, p.20). Professions are considered to occupy jurisdictions, with jurisdictions shifting over time as professions create their work and are in turn created by it. Abbott argued that jurisdictions are exclusive and, as a consequence, professions do not evolve independent of each other but constitute an interdependent system.

Even small changes disrupt the sensitive balance of jurisdictions between professions, as situated approaches show (Sanders et al. 2014). As part of a larger study, Sanders et al. (2014) interviewed physiotherapists who were implementing a new way of managing back pain. The participants now felt more able to help patients who had complex back pain, and more efficient with case management. In addition, they "found their work more interesting and rewarding and also felt that their standing as a profession, in the eyes of GPs, was enhanced" (Sanders et al. 2014, p.108). Although not without its challenges, the new system had offered physiotherapists an opportunity to extend their repertoire of skills and take more exclusive ownership of the back pain care jurisdiction.

Smaller healthcare professions - and by implication their clients - are at a disadvantage if practice change research gives insufficient consideration to

their specific relations with jurisdictions. Daley (2001) conducted 80 semi-structured interviews to explore how knowledge from continuing professional education was made meaningful in practice by social workers, lawyers, adult educators and nurses. The process happened in slightly different ways across the groups, which seemed to be related to the nature of their practice. Implementation studies still frequently concentrate on doctors (who have the highest status) or nurses (the largest body), or healthcare professions as a generic group, but a profession lens suggests the different aims, client populations, research literature, arrangements and practices of professions have potentially profound implications for implementation.

If jurisdictional shifts are relevant to practice change - or lack of it - *between* professions, it follows that *within*-profession interdependencies will also apply, particularly if that profession serves a diverse range of jurisdictions. Taking theory of relations between the state, healthcare professions and gender into account (Bourgeault 2017), this may also be particularly pertinent where a healthcare profession is predominantly female and state-funded, has relative clinical autonomy, and is focused on developing its influence and visibility.

1.2.3.1 Sociological framings of work and invisible work

Appreciating why inter- and intra-profession interdependencies relate to the work of practice change depends on a sociological rather than a common-sense framing of the word 'work', including the idea of 'invisible work' (Daniels 1987). Daniels' original thesis drew attention to work as effortful activity in domestic, community and workplace spheres that maintains and creates the fabric of social life. She also highlighted the social consequences of undervaluing work which is unremunerated, gendered and less visible (Daniels 1987). In the ensuing years scholars have applied the idea widely to bring attention to many types of informal, behind-the-scenes labour that perform important social functions but may otherwise go unnoticed (Hatton 2017; Star and Strauss 1999). Their insights suggest that, to understand what it really takes, the work of practice change needs to be noticed and patterns of visibility and invisibility discerned.

1.2.4   Intersecting lenses: implementation-practice-profession

Section 1.2 provided an introduction to scholarly literature, much of it sociological, which has raised the profile of practice change as 'work' and done so much to explicate its nature. As this literature is vast, rich and diverse, I channelled it through three lenses and showed how they intersect to form a route for the practical purpose of this thesis.

This implementation-practice-profession lens is founded on sociological understandings of work and its visibility. It assumes that, in routine clinical practice:

- Interventions may be more or less discernible as part of practices nested within other practices
- The trajectory of practice change may depend on collective work to change the immediate practice context and / or architecture holding practice(s) in place
- There will be profession- and jurisdiction-specific features at play.

In section 1.3 I will make the case for exploring this empirically with speech and language therapy as the exemplar profession. In section 1.4 I will go on to show why the profession's jurisdiction of children with SSD has the potential to offer rich insights into what practice change is and what it really takes.

1.3   Why speech and language therapy?

In this section, I discuss the rationale for exploring practice change empirically through the speech and language therapy profession. I argue the profession needs more basic sociological research into the work of practice change, and that my particular experience makes me well placed to do it.

1.3.1   The speech and language therapy profession in the UK

The speech and language therapy profession exists to make a difference to people with communication and swallowing difficulties through therapeutic relationships and intervention, research and advocacy.

Communication is a fundamental part of being human that most people take for granted. It is integral to all social relationships, both with oneself (internal

conversations) and with others. We communicate meaning in many ways, including vocalising, speaking, silence, hearing, listening, ignoring, understanding, turn-taking, reading, writing, body language, facial expression, tone, symbols and signing. Communication difficulties include stammering, aphasia, language disorder and dysarthria. They can be congenital or acquired, and be of unknown origin or associated with a condition such as Parkinson's disease, learning disability, cleft palate, stroke or dementia.

People with communication difficulties are vulnerable socially, educationally, emotionally and vocationally. Having analysed epidemiological and economic data, Ruben (2000) concluded this disadvantage is growing because changes in the distribution of employment over the last century away from manual jobs mean that individual and societal economic wellbeing is increasingly dependent on oral communication. Professional and user organisations around the world with an interest in communication difficulties therefore share three linked beliefs: that the opportunity to communicate is a basic human right, that everybody has the potential to communicate, and that skilled help should be available to those who need it (ICP 2014).

Speech therapy was formally established in the UK in 1945 when the two very different founding strands from biomedical and speech and drama traditions merged to form one professional body (Robertson et al. 1995). The first all-graduate entry into the profession was in 1984, the first speech therapy professor was appointed in 1990, and the professional body has an international journal (impact factor 2.195[1]). In 1991 the profession voted to change its name to speech and language therapy, published professional standards, and introduced non-statutory registration. In 1998 members of the by then Royal College of Speech & Language Therapists voted in favour of regulation, which is now under the auspices of the Health and Care Professions Council. From 7,303 registrants in 2001 (the first year of compulsory registration and protection of title) the UK regulatory body now oversees 15,886 registered speech and language therapists[2].

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[1] 4th August 2017
[2] Source http://www.hcpc-uk.co.uk/aboutregistration/theregister/stats/ 12th February 2017

In 1973, the NHS was given statutory responsibility for speech and language therapy provision, a move which brought a career structure (Robertson et al. 1995). Members of the overwhelmingly female profession eventually won a landmark European Union equal pay for work of equal value case in 1997 by comparing their work with that of clinical psychologists (Morgan 2006). An education and workforce report on speech and language therapy in Scotland from 2007 to 2012 found 98% of staff were female. Although total staff numbers had remained similar, the proportion of support workers increased from 13% to 16%, while the proportion of higher banded posts - especially band seven - reduced (NES 2013). The authors estimated 85% of registered speech and language therapists in Scotland worked in the NHS, and that, although met and unmet need was "extremely difficult to quantify" (NES 2013, p.vii), demand for their services was likely to continue to increase.

Outward appearances of the speech and language therapy profession's development include its rapidly growing knowledge base, expanding scope of practice, and active professional bodies (Stansfield and Barrett 2013). However, rather than taking these at face value, speech and language therapy's progression in the UK *could* fit Abbott's rather disconcerting depiction of a profession "on the prowl" (1988, p.98). The profession could be seen to have pursued status and monopoly over many years through protectionism, while at the same time using communication as a "conveniently vague heading" (Abbott 1988, p.22) to invade other jurisdictions in an entrepreneurial way. These include jurisdictions as diverse as swallowing, literacy, public health, criminal justice, spinal cord injury, baby signing and persistent cough. This role expansion has necessitated both a growth in numbers and "internal subordination of routine work…a characteristic strategy of professions claiming more jurisdiction than they can effectively serve" (Abbott 1988, p.25).

1.3.2 An implementation-practice-profession view of speech and language therapy

Implementation studies involving the speech and language therapy profession remain in their infancy, and fewer still are underpinned by theory. In the UK, James (2011, see 1.2.1.4) engaged with Normalisation Process Theory, as did Masterson-Algar et al. (2017) when developing their process evaluation

protocol for a randomised controlled trial of routine speech and language therapy interventions for people with Parkinson's disease. Shrubsole et al. (2018) used the Theoretical Domains Framework to explore the influences on aphasia guideline implementation reported by speech-language pathologists in Australia and, in her doctoral thesis, Douglas (2013) employed PARiHS in a mixed method study of speech-language pathologists' perceptions of memory aids for people with dementia in nursing homes in the United States.

Identifying studies which have made explicit use of a practice theory is more challenging, as practice theories are more diverse than implementation theories, and are not necessarily focused on a planned or specific change. 'Practice' is also the dominant term for describing what speech and language therapists do. Perhaps unsurprisingly, examples are found in studies where there is a strong influence from education. Verdon, for example, used Engström's cultural historical activity theory during her PhD, which was co-supervised across speech and language therapy and education (Verdon 2015). Martin (2008) applied the same theory to support and analyse the inter-professional learning in a project to integrate speech and language therapy in secondary schools. Concerned that the cultural and institutional focus of cultural historical activity theory is too remote from the particulars of individual practitioners, and inspired by scholars including Pierre Bourdieu and Robert Putnam, Forbes and McCartney (2010) introduced an alternative frame of social capital theory to map practitioner interrelationships in children's services. This was recently applied by McKean et al. (2017) in a qualitative case study of collaborative working for children with speech, language and communication needs to understand how this played out at governance, school and practitioner levels.

Systematic review methods enable implementation or practice theory to be brought to bear on a topic, even if the primary studies did not employ it. In a scoping review of perspectives on implementation represented in speech and language therapy research literature (Nicoll 2012), I used Normalisation Process Theory as an analysis tool. Included papers had to report on studies of real-world clinical contexts, reporting at least two of therapist / researcher /

client[3] perspectives in the same paper. The ten identified papers covered a wide range of client groups and topics and mostly analysed service user or family and professional perspectives; only one set out to contrast researcher and therapist views. The themes from the analysis (working with change; valuing perspectives; supporting enactment; planning and theorising; moving beyond the individual) informed the methodology of this thesis. Analysis also suggested possible underestimation of the type and level of support and training needed by speech and language therapists to enact new ways of practice, and of the work involved in letting go of their hard-won professional autonomy in favour of a more distributed system.

Practice magazines and books contain many clues to the profession-specific activities, tools and jurisdictional concerns that are part and parcel of routine speech and language therapy practice. Seminal books have covered intervention frameworks and processes (Bunning 2004), professional practice development (Anderson and van der Gaag 2005), prioritisation (Roulstone 2007), embedding evidence-based practice (Roddam and Skeat 2010), therapeutic processes (Fourie 2011), and most recently professional identity (Stokes and McCormick 2015). The content is driven by expertise, experience, and interest in advancing the profession rather than empirical implementation-practice research.

Empirical research of profession-specific routines is rare in speech and language therapy, although secondary analysis of metaphors 16 speech-language pathologists used in qualitative interviews when referring to caseload management (sport, scales, war) supports the case for more (Kenny and Lincoln 2012). Similarly, Care Aims is a tool which has been widely applied by speech and language therapy services to inform reflective clinical reasoning around cases, caseloads and services. Although it features in two chapters of of a book - one on the model itself by the Care Aims developer (Malcomess 2005) and the other on its implementation by her associate (Beirne 2005) - there has been almost no published empirical research. A recent exception noted that the Care Aims episodes of care structure created difficulties for

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[3] 'Clients' was defined very broadly to include other professional groups

transitions from child to adult speech and language therapy services of school leavers with learning disabilities (McCartney and Muir 2017).

The need for the profession to engage more critically with potentially uncomfortable questions around intervention and practice was also highlighted by Stokes and McCormick (2015). Establishing a new postgraduate entry speech and language therapy programme, they deliberately sought to address intuitive, tacit and spiritual aspects of the work, shared territory, and individual and collective clinical reasoning. In preparing students, they found "the need to teach them what intervention actually is and what has been found to be effective" (p.8) a particular challenge, as routine intervention is under-theorised, depends on improvisation, and is hard to evidence.

Overall, the dearth of speech and language therapy research through an implementation-practice lens is an important research gap. It could indicate unfamiliarity or discomfort with the theoretical language; a lack of joined-up thinking between intervention and implementation researchers in the field; and a lack of recognition within the wider healthcare research community of what research into the work of speech and language therapists has to offer.

1.3.3 My relationship with the speech and language therapy profession

My embeddedness in the speech and language therapy profession presents challenges for doing this research, but my unique relationship with it also brings advantages. I qualified in 1988, served on the then College of Speech and Language Therapists' Council at a time of great change from 1990-1994, and was seconded for a day a week to coordinate the profession's Golden Jubilee in 1995. This unusual situation gave me privileged access to information about the profession, and the opportunity to debate and be involved in decisions with its leaders - managers, researchers, strategists - from a formative age.

I owned, published and edited Speech & Language Therapy in Practice magazine from 1997-2011. This involved interacting and negotiating content with therapists and researchers across the UK and beyond. In addition to comments on the magazine's practical value, acknowledgements received as the last issue was published included that it was 'slightly leftfield', didn't 'toe the party line', and - from one of the profession's research leaders - was

'informative, educational, controversial, always interesting and sometimes irritating'. I have worked to have a similarly critical questioning stance throughout this research, whilst also starting from the assumption that the profession exists to make a difference to the lives of people with communication difficulties.

In everything from the framing of the problem, through research design choices to conduct and analysis of the study and selection of conclusions, I have reflected critically on how my own assumptions, experiences and reactions may have shaped or constrained how the thesis unfolded. In this I have been assisted by my intimate involvement with practice change in another profession (midwifery) as a user representative. My relative isolation as a speech and language therapist in a multidisciplinary Unit of applied health researchers - with supervisors who have a background in sociology - has also helped me figure out what is taken-for-granted in speech and language therapy.

Having been out of clinical practice since 2002, I am no longer quite a practitioner but neither am I an established researcher, and an ethnographic sensibility has been helpful. Like music therapist Alison Ledger when she was doing doctoral research in music therapy service development:

> I found myself uncomfortable with a polarized view of the researcher role as insider versus outsider, practitioner versus researcher (Ledger 2010, p.293).

As depicted in Figure 1-1, I too emphasise / de-emphasise, am more / less comfortable with, or identify more / less strongly with different aspects of myself depending on the circumstances. It has been helpful to use this awareness strategically when I want to be more uncertain, questioning and critical from different perspectives.

Figure 1-1: Identity graph

Practitioner

Insider ——————|—————— Outsider

Researcher
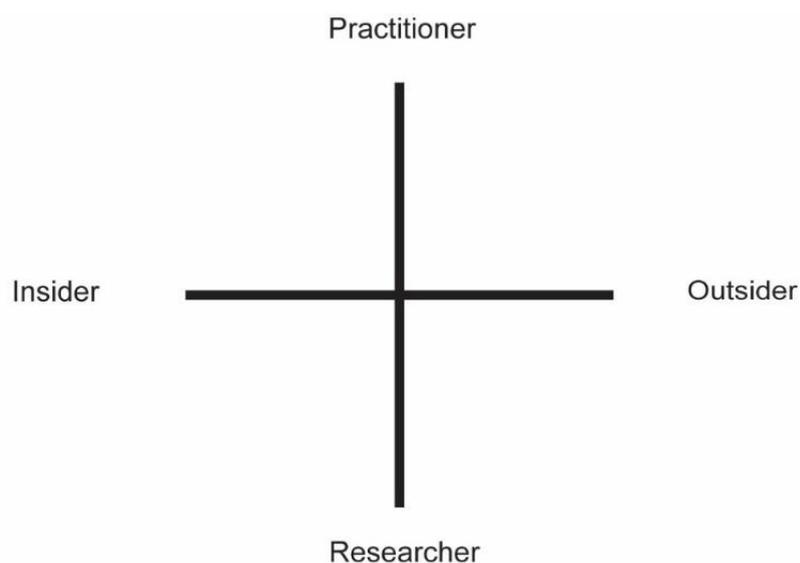
1.4 Why the jurisdiction of speech sound difficulties?

In this section I explain why I purposefully chose the jurisdiction of speech sound difficulties / disorders (SSD). Firstly, speech and language therapy occupies this jurisdiction. Secondly, as a high usage group, there was potential to benefit them and services. Thirdly, there was a window of opportunity to capitalise on naturally occurring practice change. Finally, my relationship with SSD comes from several perspectives, sensitising me to the complexities.

1.4.1 The speech and language therapy profession as occupants of the speech sound difficulties jurisdiction

One strand of the modern speech and language therapy profession in the UK grew out of a remedial speech tradition, which was originally a jurisdiction of the Association of Teachers of Speech and Drama (Robertson et al. 1995). Contemporary teachers of speech and drama (also comprising teachers of effective communication, voice, or elocution) may have considerable knowledge of speech production and phonetics. However, there is little overlap in jurisdiction as their focus is on personal improvement and performance, not on intervention where there is a speech sound disorder.

This lack of overlap may well have arisen partly because speech and language therapists squeezed these other professions out but, from Abbott's (1988)

perspective, *possession* of a heartland is insufficient, and occupying professions will also seek to *defend* their jurisdiction. Two speech-language pathologists in Australia recently felt it necessary to mount defensive international action against 'crank' interventions (Bowen and Snow 2017). It is not clear to what extent the perceived threat differs across countries which have different healthcare and education systems, but Bowen and Snow are concerned about use of such interventions within as well as outside the profession. Anecdotally, in the UK at least, the SSD heartland faces more imminent disruption within the profession as services continue to be cut and overall jurisdiction continues to expand.

1.4.2 The speech sound difficulties jurisdiction

Speech sounds convey meaning through differentiating words that would otherwise sound the same. All languages use a range of consonants and vowels in various word positions and combinations, and each language has a typical order of speech sound development. For native speakers of English this process is usually complete by 8 years (Wren et al. 2012).

Children with developmental SSD of unknown origin[4] form a heterogeneous group (some with other co-occurring or related communication difficulties), and there is no universally agreed classification system (Waring and Knight 2013). This means the same children are referred to by a variety of labels. Umbrella terms usually comprise adjectives (speech, speech sound, phonological, developmental speech, articulation) and a noun (difficulty, disorder, impairment, delay, problem). This thesis uses the acronym SSD as it can be read either as speech sound disorders (the most common term in contemporary international literature), or speech sound difficulties (which feels more clinically appropriate).

1.4.2.1 *The impact of speech sound difficulties*

Children with SSD struggle to make themselves as intelligible as their peers. They may not be able to make the full range of speech sounds; may substitute some speech sounds with other speech sounds; may miss out parts of words;

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[4] Also referred to as primary SSD

and may struggle with the rhythm and intonation that helps other people understand their speech. Defined formally, children with SSD:

> can have any combination of difficulties with perception, articulation/motor production, and/or phonological representation of speech segments (consonants and vowels), phonotactics (syllable and word shapes), and prosody (lexical and grammatical tones, rhythm, stress, and intonation) that may impact speech intelligibility and acceptability (International Expert Panel on Multilingual Children's Speech 2012)

The reality of SSD, however, cannot be conveyed in writing; this 41 second audio clip of a school aged child talking to his mother for a radio programme is more illuminating: http://www.bbc.co.uk/programmes/p03br51b.

In a systematic review, McCormack et al. (2009) found SSDs are associated with a range of educational, social and health outcomes across the lifespan, including vulnerability with literacy and susceptibility to employment discrimination. A qualitative study of the everyday lives of six school-aged children with SSD and their siblings, friends, parents, grandparents and teachers contrasted their relative confidence in the home environment with the frustration, discomfort and embarrassment experienced at school and in other public contexts (McLeod et al. 2013a). Qualitative studies have also identified the extra pressure on siblings who feel they have to act as interpreters and protectors (Barr et al. 2008), and the ongoing frustration experienced by affected children, their family and their teachers as seen through the lens of the ICF-CY[5] Activity and Participation framework (McCormack et al. 2010).

1.4.2.2 Epidemiology and intervention evidence

Estimates of SSD prevalence vary depending on the chosen criteria, population and method. In a systematic review, it ranged from 2.3%-24.6% for children aged between 5 and 7 years over three studies (Law et al. 2000). More recent analysis of prospectively collected data from a large UK population-based cohort led to a prevalence estimate of 3.6% for persistent SSD at 8 years (Wren et al. 2016).

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[5] World Health Organisation International Classification of Functioning, Disability and Health – Children and Youth

UK clinical epidemiological data (Broomfield and Dodd 2004) found children with SSD made up almost half the typical caseload of community generalist paediatric therapists, over three quarters between the ages of 3 and 6 at referral. This offers a window of opportunity for intervention, as speech sound error rate at 5 years is a "powerful predictor" of the problem persisting at 8 years (Roulstone et al. 2009, p.390) when implications are more far-reaching.

Empirical evidence provides support for the effectiveness of speech and language therapy intervention for SSD compared with no treatment. A Cochrane review and meta-analysis (six included studies) concluded that intervention was particularly effective if delivered directly by a speech and language therapist in sufficient quantity (Law et al. 2004), although there is also support from clinical experiments for routine parental involvement (Lancaster et al. 2010). In a randomised controlled trial in a clinical service, therapy made the difference between progress and plateau. Children's SSDs improved with intervention ranging from 0-24 hours (average 5.5 hours) over six months, but did not change over the same period without it (Broomfield and Dodd 2011).

Using level of evidence according to research design as a proxy for quality, a comprehensive narrative review from 1979 to 2009 identified 134[6] intervention studies for children with SSD, of which two were meta-analyses, 20 were randomised controlled trials, 13 were controlled studies without randomisation, 56 were quasi-experimental studies (including 40 single-case experimental designs) and 44 were nonexperimental studies (Baker and McLeod 2011). Excluding the systematic reviews, 78% of these had up to 20 participants, and the focus was almost exclusively on efficacy rather than effectiveness. The studies comprised 46 distinct intervention approaches, with seven distinct approaches to target selection, but 94/134 reported results for one approach only. Baker and McLeod concluded that well-designed comparative studies are needed, but at present:

> it is better for children who have a phonological impairment to receive intervention than no intervention at all (2011, p.115).

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[6] One of which reported two investigations using different designs, making the total 135

Efforts are ongoing to build, refine and identify gaps in the evidence base for SSD interventions, with a notable increase in the quantity and quality of systematic reviews. A newly published systematic review and classification of interventions from 26 studies identified considerable gaps in the distribution of research across different types of SSD intervention, and a preponderance of good quality but lower-grade evidence (Wren et al. 2018). A systematic review of 61 papers reporting on involvement of parents in SSD intervention confirmed the prevalence of this practice but summaries of what it entailed were constrained by the limited details provided (Sugden et al. 2016). Natalie Hegarty's PhD thesis due for submission in 2018 will include a systematic review with a focus on evidence for dosage of SSD interventions. A protocol for a Cochrane Review on speech and language therapy interventions for children with primary speech and/or language disorders (Law et al. 2017) has phonology and adverse effects as two of three primary outcomes, and phonological awareness as a secondary outcome.

Efforts are also ongoing to communicate the findings of research in a way that is accessible to speech and language therapists in routine practice. The What Works database (Law et al. 2015) was developed out of the Better Communication Research Programme in England to help therapists decide which interventions to use with children. Seventeen speech sound interventions that are not dependent on access to specialist technology were judged to have sufficient evidence to support implementation (counted from Law et al. 2012). This UK database is regularly updated, as is the SpeechBITE database in Australia, and the American Speech-Language-Hearing Association's Evidence Map for Speech Sound Disorders. The UK Royal College of Speech and Language Therapists collates and publishes guidelines, standards, policy publications, position papers, resource manuals and decision-making tools on its website to help members (therapists and assistants) use evidence-based practice; this includes recently updated guidelines on transcription of children's speech developed by an expert group (Child Speech Disorder Research Network 2017).

1.4.3 Fit of the speech sound difficulties jurisdiction for an implementation-practice-profession lens

Reflecting on how and why SSD management and knowledge have changed within living memory, Elise Baker highlighted "the paradigm shift from articulation to phonology" in the late 1970s and early 1980s as the most "revolutionary moment in the journey so far". It precipitated the present day problem for busy therapists of "a smorgasbord of approaches to choose from" (Baker 2006, p.156), with little comparative research to guide purposeful choices. When planning this study there were signs that, after a long period of stasis, some therapists in Scotland had renewed enthusiasm for speech sound work and were engaging with a variety of interventions. This offered a window of opportunity to capitalise on a naturally occurring challenge to usual practice, as disruption tends to render underlying mechanisms more salient (Danermark et al. 2002). It also offered a chance to compare practice change to practice which had not been similarly disrupted.

In addition, compared to other jurisdictions of the profession, SSD work is largely reserved to speech and language therapists, rather than distributed through a multidisciplinary team. This may make it a more extreme case, meaning the mechanisms at play in the process of change are experienced in a purer form so can be theorised more easily (Danermark et al. 2002).

The SSD jurisdiction raises other sociologically interesting questions which may be relevant to a study of practice change:

- Generally, children with SSD get better. Perhaps clinicians will only perceive a *need* for SSD practice change if spaces for sensemaking conversations about new interventions are deliberately created (Jordan et al. 2009)?
- The majority of SSD work is done by NHS community generalist speech and language therapists. Within the profession, these tend to be itinerant, lower banded and entry positions. If, as a consequence, this work is perceived as lower status, might practice change in other jurisdictions be a higher priority?

- Posts are rarely advertised with SSD as a specialty. Joffe and Pring suggested that, as surveyed therapists working with children with SSD did not identify as specialists, they may regard this intervention as "unchallenging or routine" (2008, p.160). However, given that a Scottish Clinical Excellence Network in SSD was launched in 2017, are changes afoot?

- Within individual SSD sessions there is asymmetry of knowledge with parents, as the therapist's micro-technical facilitative skills do not translate easily (Gardner 2004). Collectively there is no SSD user advocacy group. Might these parents have limited perception of practice problems and limited power to campaign for change compared to those in higher profile jurisdictions such as autism?

- Positive outcomes in research efficacy studies may be due to intensity of intervention (Lancaster et al. 2010), which makes application unrealistic when many services have unacceptable waiting times and offer only "low dosage" contact (Bercow 2008). If constraints on sessions are imposed, will therapists see the point of investing in more tailored approaches?

- Therapists tend to describe speech sound work in terms of activities and resources rather than interventions (Roulstone et al. 2012), and relatively few SSD interventions are well-specified through a manual (Law et al. 2012). As the same activities and resources can operationalise a range of interventions, do therapists see them as key to a successful outcome, rather than different underlying logics?

1.4.4 My relationship with the speech sound difficulties jurisdiction

Professionally and personally I have a historical insider relationship with SSD. From a more outsider perspective, I also observed and reported on some of the debates around research and practice in SSD over a number of years.

In 1993, as a community generalist, I participated in the field trials for Metaphon, a phonologically-based intervention for children with SSD developed at Queen Margaret College in Scotland. In addition to intensive training, new materials and a different - and to me exciting - approach, this required me to do fuller assessment and accept randomisation of clients (to control, or to weekly

intervention over six weeks for phase I only, or ten weeks for phases I and II) (Dean et al. 1995). The researchers were available for discussion, and visited to videotape sessions and offer feedback. As a friend was also participating, we spent many hours reflecting on the methods and responses from children and parents. Metaphon's flexible ideas - meta-linguistics; finding a common and fun way to discuss speech sounds; setting up interaction where the communicative power of speech sounds would be experienced - and the effort to evaluate it in real settings profoundly influenced my practice well beyond children with SSD.

When my younger son (born 2000) started to speak, he had SSD, in particular the structural problem of initial consonant deletion. This meant he said the same word 'all' for all, ball, Paul, tall, doll, fall, stall, small, shawl, call and crawl, although he could make all the missing sounds and use them appropriately in other word positions. This is not part of normal development in English, so is a red flag for early intervention. My anxiety may have been heightened by my knowledge of the implications, but equally I was able to address it in a low key, natural way rather than having to take him through referral, assessment and therapy appointments with a stranger. It was particularly interesting to see how self-aware my son was, and his responses to the problem and to different strategies. I also observed the awkwardness and uncertainty a child's disordered speech provokes in other people.

Through Speech & Language Therapy in Practice magazine, I was aware of - and contributed to - international efforts to bridge research and practice. Contacts included speech-language pathologist, SSD specialist and knowledge broker[7] Caroline Bowen who is based in Australia, and I became a member of her international phono-tx yahoo group. I attended one of Caroline's first courses in the UK, as well as a training event in Bristol with Australian SSD researcher Sharynne McLeod, and interviewed both for features on the magazine's website (McLeod and Nicoll 2010; Nicoll and Bowen 2011). Although I had no notion I would do research in this field, the experience heightened my sensitivity to the complexity of SSD and of implementation.

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[7] My description

1.5 What do therapists do with children with speech sound difficulties?

In speech and language therapy, the most informative studies for my research interest investigate through an evidence-based practice lens what therapists actually do with children with SSD. Identifying and reviewing this growing international body of literature provides both technical and methodological context for this thesis by introducing key terminology and tensions around SSD intervention and implementation.

The authors in the identified studies variously describe practice, seek to understand it, investigate whether it has changed, and aim to change it; none set out to explain how and why it has changed. Here I organise their insights through an implementation-practice-profession lens by sorting them into underlying purposes of de-implementation, raising standards, developing guidance, describing practice, and understanding practice.

1.5.1 De-implementing a practice

Non-speech oromotor exercises (NSOMEs) (see Lee and Gibbon's 2015 Cochrane review) have little support in academic circles, so the first objective is to de-implement this controversial practice. Practitioner surveys on the use of NSOMEs in the United States (Lof and Watson 2008, n=537), India (Thomas and Kaipa 2015, n=127) and the Republic of Ireland (Lee and Moore 2014, n=39) suggested activities such as blowing and repeated tongue movements were widely used in combination with other approaches for children, including those with SSD. In comparing the different perspectives of clinicians who use NSOMEs and researchers through a qualitative in-depth interview study, Muttiah et al. (2011, p.55) hoped to "further the dialogue" on a way forward.

1.5.2 Raising standards

A second objective is to raise standards and aspirations of practice internationally with children from multilingual backgrounds, including those with SSD, through promoting expert consensus. Williams and McLeod (2012) surveyed 118 Australian speech and language therapists who worked with children from multilingual backgrounds. While the majority of therapists were

monolingual, children on their caseloads spoke 65 different primary languages. Given that patterns of speech sound presence and development differ across languages - and that intervention for SSD is through the medium of language - linguistic and associated cultural diversity adds complexity to every aspect of an already complex process.

McLeod et al. (2013b) convened a 57-member expert international panel on multilingual children's speech to develop a position paper. An initial six hour discussion workshop involving 14 members was recorded, transcribed and analysed using Engeström's practice-based Cultural-Historical Activity Theory as a heuristic framework (Verdon et al. 2015). This identified tensions and contradictions between ideals and the reality of practice in terms of people, practicalities and policy. Rather than a problem, these tensions are seen as a route to empowering individual therapists to make even one practice change because:

> if multiple positive changes are made by multiple practitioners over time, the eventual negotiation between these elements has the potential to change the activity system (Verdon et al. 2015, p.59)

1.5.3   Developing guidance

A third objective is to develop in-depth guidance on an aspect of practice, working with parents. Watts Pappas et al. (2008) surveyed 277 paediatric speech-language pathologists in Australia who work with children with SSD about how they typically involve parents, and how they (the therapists) feel about this. Those in an education setting were significantly less likely to have a parent present or participating, while those trained in specific approaches to language delay and dysfluency which incorporate parental involvement were significantly more likely to carry this over to SSD intervention.

A newly published detailed Australian survey of practice in involving parents of children with phonology-based SSD (n=288) (Sugden et al. 2017) confirmed that education settings are not conducive. It also pointed to intriguing differences between the type of home practice tasks provided by private practitioners and those in community or education settings, and an overall preference for parents learning through observing. In addition, nearly a quarter "touched on the idea that they are limited in the amount of intervention that they

are able to provide to children with SSD, and involved parents partly to overcome this service delivery barrier" (Sugden et al. 2017, p.6).

In a longitudinal qualitative study, Watts Pappas et al. (2016) interviewed parents of six children with mild/moderate SSD at three time points before, during and after a six (or in one case four) week block of intervention to understand how they had been involved, and how they felt about this. Overall the parental involvement was limited. However, the six children were equally divided between three therapists, and each "worked in a similar way with the parents of the two children they served" (Watts Pappas et al. 2016, p.234). Although focused on parents' expectations and experiences - which were largely around the therapist 'fixing' the child with parents doing homework activities - analysis suggested therapists could set the stage for greater involvement by providing opportunities and support.

1.5.4 Describing practice

The fourth objective is to describe the research-practice gap or, more broadly, research-practice-client gaps. The most popular method is surveys, with at least four related to SSD in process in the UK[8] (how therapists work with assistants; intervention approaches, amount and intensity routinely provided, and how therapists keep up-to-date with research; use of technology; evidence-based practice and continuing professional development in relation to intervention).

National surveys around SSD intervention practice have previously been undertaken in the UK (Joffe and Pring 2008, n=98; Rogers and Stackhouse 2014, n=65), the Western Cape of South Africa (Pascoe et al. 2010, n=29), the United States (Brumbaugh and Smit 2013, n=379), Australia (McLeod and Baker 2014, n=231) and Portugal (Oliviera et al. 2015, n=88). Lee and Moore (2014, n=36) appended a section on SSD therapy techniques to their Republic of Ireland survey about NSOME use. Two surveys have focused on SSD assessment practices: Priester et al. (2009, n=85) in the Netherlands, and Skahan et al. (2007, n=312) in the United States.

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[8] Publicised via Royal College of Speech & Language Therapists and social media between June 2016 and February 2017

These surveys varied in quality of design, sampling, response and reporting, but provide intriguing snapshots of patterns in different contexts. Their construction also reveals researchers' evolving interests, and shifts in thinking around what might constitute practice. Overall, they highlight the slipperiness of terminology, with words including interventions / therapies / therapy techniques / approaches / practices / intervention approaches / methods / treatment approaches used interchangeably. They also show the importance and challenge of accounting for factors beyond the intervention and individual respondent, such as service delivery constraints and mandates, and the wider practice context, such as healthcare systems and linguistic diversity. This was reflected in an SSD research priority setting exercise (Wren et al. 2015), with service delivery and approaches to intervention the highest scoring themes.

Joffe and Pring (2008) restricted their survey questions to assessments and interventions, with two on caseload proportions. They categorised interventions as popular (auditory discrimination, meaningful minimal contrasts, phonological awareness, parental involvement), unpopular (e.g. Cycles, Core Vocabulary, maximal contrasts), optional (e.g. non-speech oromotor exercises, Nuffield) and divisive (e.g. Metaphon, Cued Articulation). Of the 98 respondents, 83 used the South Tyneside Assessment of Phonology (STAP). Joffe and Pring concluded practice was eclectic, and lacked detailed assessment of the underlying nature of the impairment.

More recently, Rogers and Stackhouse (2014) highlighted findings from a questionnaire asking UK SLTs what they do when working with children with SSD. They categorised treatment approaches as parent / staff involvement; Metaphon / phonological awareness; minimal pairs; and combined / eclectic. The most popular frequency was weekly. Roughly half the 65 respondents worked in the public sector, two fifths in private practice, and the remainder in both, and the thematic map of responses to open questions showed differences. While benefits of private sector working included an ability to use preferred approaches and make progress, public sector constraints included lack of flexibility, reliance on non-trained staff or parents, and limitations imposed by prioritisation.

Reporting on a 2011 electronic survey in the United States of therapists who work with children with SSD aged 3-6, Brumbaugh and Smit (2013) treated interventions / techniques and service delivery options as separate descriptive categories, and described approaches as traditional and non-traditional. They also used questions about intervention practices to augment findings around later answers to questions about named interventions. Most children were seen in preschool environments, small groups were popular, and just under half the children were typically receiving 30-60 minutes weekly whether individually, in a group, or in a combination. A traditional sequence of intervention was used by 60-75%, with phonological awareness, minimal pairs, Cycles and whole language also featuring, and half using behavioural methods. Eighty three per cent were not familiar with Metaphon, 70% were not familiar with complexity/least knowledge, and 41% were not familiar with Multiple Oppositions. Two thirds used traditional techniques of elicitation frequently, and half used the phonological technique of developing a label for a phoneme.

McLeod and Baker (2014) also broadened the definition of practice by including assessment, analysis, target selection, intervention, service delivery and family involvement in their survey. Completed by 231/322 Australian speech-language pathologists on arrival at SSD seminars, the cohort represented private practice, education and community health, and a third had 40-70% of their caseloads as children with SSD. Eight approaches were frequently used (auditory discrimination, minimal pairs, Cued Articulation, phonological awareness, traditional articulation therapy, auditory bombardment, Nuffield, Core Vocabulary), and 17 never used by at least 50% of respondents (including Stimulability, Multiple Oppositions, SAILS, psycholinguistic). A traditional approach to target selection (stimulable sounds, early developing sounds, sounds in error across all positions) was preferred but, compared with a 2004 survey by the same authors, an increased percentage of respondents were giving priority to non-stimulable (20.3% vs 8.9%) and later developing sounds (15.2% vs 4.8%). Most intervention took place in a clinic (73.8%) or school (57.6%), with 25.2% in the child's home. Parent training and home programmes were used by around two thirds of respondents, and groups by just over a third.

1.5.5 Describing and understanding practice

In addition to describing practice, some research seeks to understand it. In a Hong Kong survey, To et al. (2012, n=97) used an intervention intensity lens to suggest that frequency and duration were associated with caseload and setting rather than interventions or clients.

In the United States, Farquharson et al. (2014) coded written treatment goals from IEPs[9] for 146 school-age children with SSD for quality and dominant theoretical framework: cognitive-linguistic (phonological) or sensory-motor (articulatory). None of the goals simultaneously reflected both theoretical perspectives, and none focused on speech input. Short-term goals were overwhelmingly sensory-motor (88% vs 12%) and long-term goals were divided between cognitive-linguistic (53%) and sensory-motor (46%). While sensory-motor goals were more concrete, definable and measurable, cognitive-linguistic ones were more abstract and difficult to communicate clearly. Although this was a descriptive study, it is intriguing to wonder to what extent this formalised approach to recording goals reflected the intervention that speech-language pathologists delivered, and / or shaped how they framed their intervention.

In the UK, Sue Roulstone has long accepted that therapists "operate eclectic models and their own theories of practice" (Roulstone and Wren 2001, p.445), and has pioneered methods to describe and map these models to research findings and views from children and parents. Roulstone and Wren (2001) convened a focus group of seven experienced therapists with authority in the SSD field. They used a mix of video-based and written descriptions of children and brainstorming to elicit their therapy steps and tasks. Analysis suggested that, although each therapist had a theoretical preference, all used a mix of cognitive-linguistic, motor, and auditory-perceptual approaches. Similarly, although they took different routes, all progressed therapy in a hierarchical manner influenced by a number of factors, meaning:

> general glosses such as 'rhythm work' or 'minimal pairs' concealed work of varying nature and level (Roulstone and Wren 2001, p.443)

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[9] Individual Education Plans

To *reveal* more detail of this work, Roulstone et al. (2012) interviewed 14 speech and language therapy managers and 33 practitioners as part of the government-commissioned Better Research Communication Programme in England. Names for SSD interventions included Nuffield, phonological contrast therapy, parent workshops, phonological care pathways and traditional phonology intervention. The described interventions were categorised as programmes or packages (e.g. Metaphon, Core Vocabulary), activities (e.g. traditional articulation, minimal pair production, Cued Articulation), principles or approaches (e.g. forced alternatives), service developed programmes (no SSD examples reported), resources (e.g. Black Sheep Press), training (no SSD examples reported), models or theories (e.g. Stackhouse and Wells psycholinguistic framework) and targets (e.g. improving phonological skills).

This research programme also took account of service delivery. Participants shared an understanding of universal, targeted and specialist levels of provision. Apart from one service where the Care Aims model was used, children were categorised by impairment type, and there was no indication outcome measures were being collected at a service level.

Building on this work, the National Institute for Health Research-funded Child Talk Programme took a pragmatic, multi-phase, mixed method approach to integrating perspectives of practice, research and children / parents to develop an evidence-based framework for decision-making with preschool children with primary speech and language impairments (Roulstone et al. 2015). The therapists' perspectives on interventions were sought via focus groups, a nationwide survey, and consensus events. This led to a typology of practice aims with nine themes: speech, comprehension, expressive language, self-monitoring, generalisation, foundation skills, functional communication, adult understanding and empowerment, and adult-child interaction. Within these, activities and strategies were identified.

In relation to SSD intervention, intervention activities reported by more than 50% of therapists were auditory discrimination, practising production of sounds in isolation, sound awareness, syllable counting and minimal pairs. The only intervention strategy reported by more than 50% was adopting a hierarchical

approach (C, CV, CVC[10]). The most variation in intervention use related to speech activities: auditory bombardment/focused auditory stimulation, Cued Articulation and maximal oppositions. Cross-tabulation of strong support from survey data with strong support from a sorting activity showed most consensus in the speech theme for adopting a hierarchy (C, CV, CVC), minimal pairs, and phonological awareness; in the self-monitoring theme for minimal pairs; and in the generalisation theme for repetition/repeated practice.

Having also reviewed the intervention literature for Child Talk, Roulstone et al. observed that "in both research and practice, descriptions of interventions lack consistency and detail" (2015, p.223). Amongst therapists they found a large toolkit of interventions, a wide variety of reasons for modification, and difficulty making tacit knowledge explicit. Suggesting their framework could be used for intervention description, they noted adult-child interaction and adult understanding would be obligatory components of an intervention while others (speech, comprehension, expressive language) would be optional depending on the child's needs.

1.6 From research question to research design

My interest in practice change has evolved over 30+ years, firstly as a speech and language therapist, then as editor of 'Speech & Language Therapy in Practice' magazine, where I encouraged therapists to share the detail of their work to help readers reflect on their own practice. My insight into the social, historical and political dimensions of practice change was deepened by long-term involvement as a campaigner and service user representative in the transformation of local midwifery practice. My academic curiosity is therefore bound up with the practice theory thread of how practices exist and evolve in historical and social contexts (Reich and Hager 2014), and with a definition of implementation science which emphasises the work of practice change from a sociological perspective:

> the mobilization of human, material, and organizational resources to change practice within settings that have pre-existing structures, historical

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[10] Consonant, Consonant-Vowel, Consonant-Vowel-Consonant

> patterns of relationships and routinized ways of working (Clarke et al. 2013, p.2)

My objective is not to change or evaluate practice, but to explore, understand and explain practice change as a fundamental aspect of a particular profession's social world. By contributing basic sociological research (Blaikie 2009) to an applied field, I hope to offer a stronger foundation to which people can refer when developing and evaluating implementation initiatives.

In this chapter I framed the empirical problem as a gap between expectations of practice change in the healthcare professions and knowledge of what practice change is, what it really takes, and why there are different trajectories of change. To address this, I made a case for implementation-practice-profession research in the speech and language therapy jurisdiction of children with SSD, and reflected on what I bring to this personally and professionally.

At an abstract (conceptual) level, my research question is:

How and why have a group of helping professionals changed their practice in a jurisdiction they occupy?

With purposeful selection of subjects, this became a concrete (operational) question:

How and why have speech and language therapists changed their practice with children with SSD?

This chapter and question set the context for the research design decisions detailed in chapter 2, and the methods used to put that design into practice (chapters 3 and 4).

2 Designing the research

2.1 Research design schema

In chapter 1, I framed the practical research question that would meet my aims of understanding the what, how and why of practice change from a practice perspective. I decided to focus this basic sociological research on a speech and language therapy jurisdiction, children with SSD.

Limitations of studies are built in at the design stage, and "To arrive at reasonable expectations of social research we must take account of the kinds of things it has to explain" (Sayer 2010, p.169). In asking how and why speech and language therapists have changed their practice, I am also asking what they consider practice change to be, what it has changed from, how long this took, and who or what was involved. This entailed a research design that allowed for exploration of practice change in context over time, with opportunities to test confidence in the developing theory.

This chapter makes explicit the logic and ethics of the research design and the methodology behind it. Methodology is interpreted here as a way of thinking (about practice change, research methods, and representing empirical data) that is bound up with theoretical considerations. It is not conceived of as reducible to technical and practical issues of method (Alvesson and Kärreman 2011). This chapter is therefore at a conceptual level; how I put these ideas into practice is in chapter 3 (qualitative synthesis) and chapter 4 (primary study methods).

Figure 2-1 shows the research design schema which will be discussed in this chapter. As the bi-directional arrows indicate, this was an iterative rather than linear process, with critical realist meta-theory acting as a metaphorical umbrella for the theory structure and the case-based sociological inquiry design components.

Figure 2-1: Research design schema

Critical realism

Theory structure

| Social ontology | Explanatory frameworks | Practical social theory |

Design components

| Primary study | Sensitising theories | Qualitative synthesis |

Case-based sociological inquiry
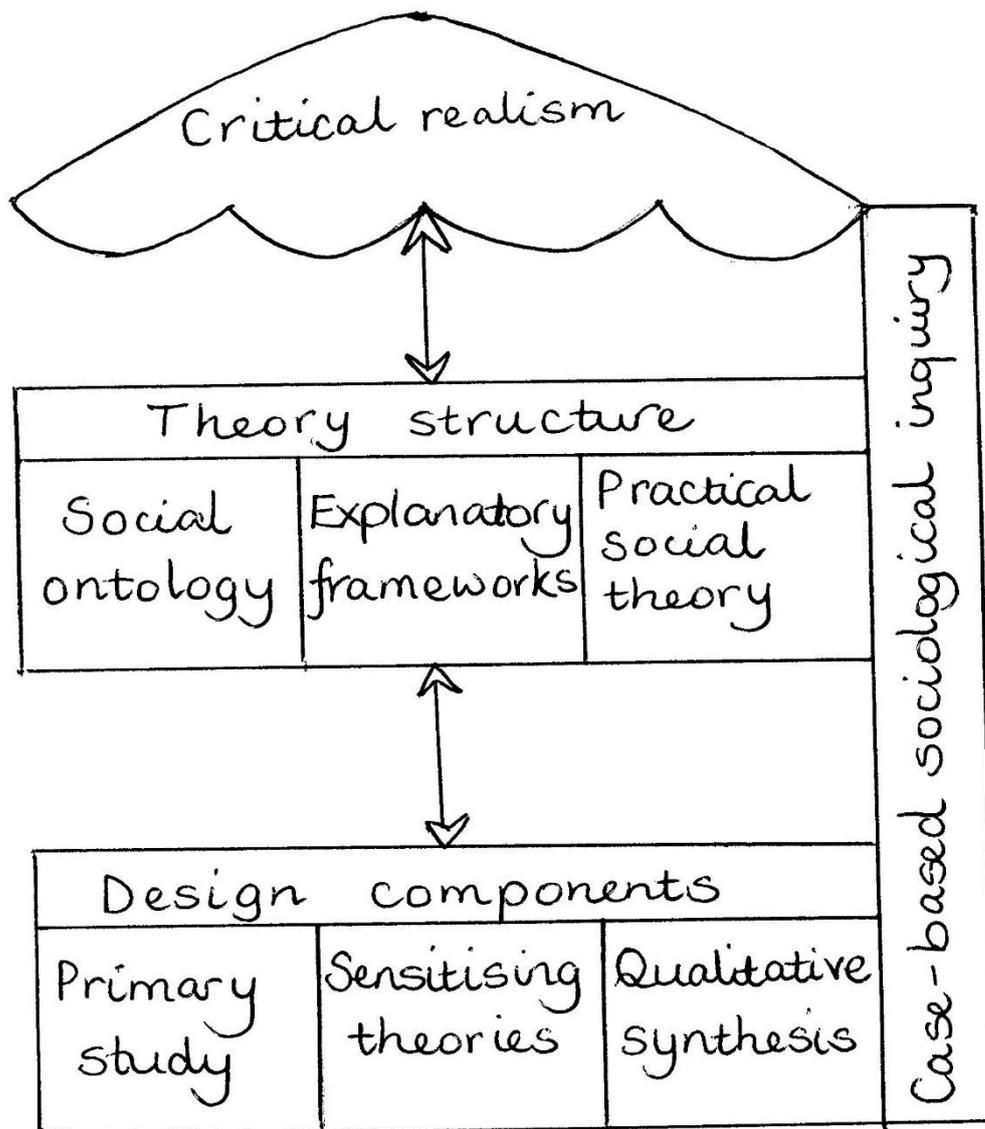
2.2 Using critical realism as a meta-theoretical umbrella

Even for scholars of critical realism, defining it "is not an easy task" (Archer et al. 2016, p.1/6). In the following sub-sections I outline my take on this meta-theoretical perspective on the world and how it shaped this thesis. In addition to specific references, in reaching this stage of understanding I am indebted to a wide range of people for their textbooks, workshops, blogs, webinars and discussions in person and online.

2.2.1   Realist social ontology with epistemological constructionism

Ontological questions ask what exists at this time independently of any particular perceptions, theories and constructions of it (Maxwell 2012). Whether ontological considerations are necessary for healthcare-related research to have a practical impact is contested, but at the very least they sensitise researchers to their own assumptions and aid reflection on how and why people might interpret problems and potential solutions differently.

Social ontology is concerned with the nature of being, becoming, existence and reality in the social world. This may include ideas about whether there are such things as agency, structure, culture, time, place, space, truth, power, sexism, class, racism or ableism.

Speech and language therapy is profoundly social as it involves people and communication. While it is unlikely any therapist would claim to offer any client the perfect service at any moment, logic dictates that unless this is held as an ontological possibility there would be no point to practice or research. If clients, therapists, researchers, the public and the media refer to and interact with this ontological reality from their different and partial perspectives, knowledge of 'what exists' can be seen as constructed, subjective, incomplete, and always open to revision.

A critical realist perspective on social ontology accepts that a social world exists independent of any particular knowledge, and in a constant state of flux. A meta-theory (theory about theory), critical realism allows for assumptions of ontological reality to be combined with epistemological constructionism (Maxwell 2012). To adapt a metaphor[11], for critical realists the map (epistemology) can never be the territory (ontology). Truth, for example, exists independent of our knowledge or certainty about it; this means that, however accurate or misplaced our certainty turns out to be, the truth will always have been the truth (Porpora 2015).

Critical realism is based on the premise that all people can know of reality is theory so that - whether we inhabit the social world as individuals or members

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[11] Attributed to Alfred Korzybski

of groups, or study it as social scientists - we have to theorise constantly about the state of affairs. Theory is always an incomplete lens, comprising what we are certain we know, what we think we might know, and what we are hypothesising (Maxwell 2012). Deciding whether our theories are relatively closer to or further from reality has to be a matter of adjudication because:

> our representations of the world are always historical, perspectival, and fallible, entailing, among other things, the necessity of methodological pluralism (Archer et al. 2016, p.1/6)

Theory is therefore conceptualised in this study as a dimension of science, a language that helps us interpret reality (Danermark et al. 2002). Section 2.2.2 considers what this social reality is like.

2.2.2 Causality, structure, agency, and anticipating outcomes

Rather than trying to control or simplify the complexity of reality, critical realism is about questioning and explaining it (Damico and Ball 2010). Two heuristics are particularly useful to researchers, the first from philosopher Roy Bhaskar. He posited that ontology is stratified into three distinct layers: mechanisms (which act together to generate events – or not), events (which give rise to empirical experiences – or don't), and experiences. While these are as real as each other:

> these three levels of reality are not naturally or normally in phase. It is the social activity of science which makes them so (Bhaskar 1975/2008, p.57)

The second heuristic, from the pioneers of realist evaluation and synthesis methodology, also has three parts capturing the idea that causality is neither linear nor fully predictable: context-mechanism-outcome configurations (Pawson and Tilley 1997). Both ways of seeing the world recognise it is socially structured and that people have agency. Pawson, for example, notes that interventions in the world do not work in themselves but in the way they pass through and are shaped by the pre-existing context and the active reasoning and reactions of users and recipients (2006). As a consequence, for realist studies:

> Contexts or causal groups are rarely just background; exploration of how the context is structured and how the key agents under study fit into it - interact with it and constitute it - is vital for explanation (Sayer 2010, p.167)

At heart, therefore, critical realists assume what emerges empirically is the result of multiple contingently conjunctural forces, with causal power lying in the particular relationship between these forces rather than in a sum or aggregate of them (Decoteau 2017). This means accepting - and somehow reflecting in research design and processes - that things happen as a consequence of a combination of factors rather than having a single, predictable cause; that the same things can happen from different combinations of factors; that different things can happen from the same combination of factors depending on the circumstances; and that explanations for the presence or absence of a particular outcome may differ (Berg-Schlosser et al. 2009).

Given that causality is understood as always contingent (dependent on circumstances and actions of people) as well as conjunctural (dependent on relationships between causal forces), the practical social theory generated through a qualitative study informed by critical realism cannot be predictive. However, rather than being irrelevant beyond the particular situation it aims to explain, it is explicitly transferable in two ways (Damico and Ball 2010). Firstly, analytic generalisation supports broad yet always fallible understanding of a social phenomenon by enabling generalisation to theory (not to a population). Secondly, there may be case-to-case transfer, where a reader decides to act on the research findings based on the evidence provided and their knowledge of their own situation. As both types of transferability constitute human theories about what is most likely to happen if things are done a certain way, they are anticipatory rather than predictive:

> Knowledge, as accumulated culture, is always limited in its ability to predict since humans are reflective and use knowledge bases to create new social and cultural forms. By understanding the sense of things, anticipation, rather than prediction, is the more reasonable result of qualitative research (Noblit and Hare 1988, pp.24-25)

Critical realism works at the level of ideas and their transfer for the purpose of practical social explanation. This thesis has a practical purpose of offering

rigorously developed, relevant theory that *people* can use, test and refine as part of their decision-making. As explained in 2.2.3, this emphasis is deliberate.

2.2.3 Human flourishing and ethics

As reflective human beings, people who identify as critical realists or select a critical realist position differ in their interpretation of what this means. However, in addition to assumptions of an independent reality, contingent conjunctural causality, and fallibility, they commonly place high value on notions of personhood and human flourishing (Porpora 2015). This goes beyond acknowledging the existence of human agency by asserting that what matters to people - what concerns them in relation to the world and makes their life worth living - really matters (Archer 1995; Sayer 2011).

People are indeed shaped and constrained by the structure of the social world, which invites the counterfactual question:

> what if things were different, wouldn't you think differently, and wouldn't you want different things? (Dyson and Brown 2006, p.41)

However, in turn, people make their mark on the social world and have the potential to change it through their labour, creativity, hopes, passions, benevolence, belonging, alienation, suffering, self-conscious choices and even their existence.

Holding assumptions about the centrality of human flourishing has consequences for research design decisions, in particular the relative weight placed on first-hand experiences and accounts. For me, it also influences what it means to be inductive in qualitative research. It is important to make this explicit, as social science investigates social scenes, the research itself is a social scene, and the discourses and choices of researchers have real consequences for people.

A human flourishing perspective implies an ethical standpoint in relation to people's agency throughout a study. This involves considering, for example, the extent to which those involved might interpret the research as promoting or alienating their human needs, and the possible experiential consequences of participating (Porter 2015). For me, this meant taking the research forward in

the spirit of an ethic of care, recognising that knowledge is political and contested and that, as a consequence, ethical practice includes explicit forward reflexivity such as voicing the hopes behind the study and considering how different people might use it for different ends (Gillies and Alldred 2012).

2.2.4 Interplay between theory and empirical work

The process of designing the study (this chapter) and framing the research question (chapter 1) demonstrate how methodology informed by critical realism depends on investing in both empirical work and theory about it, not one at the expense of the other. This interplay is crucial to establishing the validity of the research, as validity does not lie within the research method(s) (Maxwell 2012). However, guidance around what this interplay might look like in practice is limited. The following sub-sections summarise advice which has proved most useful to me: seeing the research process as ongoing conversations, and using strategies of abduction and retroduction.

2.2.4.1 Research process as ongoing conversations

To enact a realist study, Emmel (2013) suggested a researcher start with their preconceived theories - at this stage likely to be fragile ideas - then test and hone them through constant zigzagging between the developing theory and empirical evidence. Porpora likened the process to keeping two conversations going simultaneously:

> Within this double dialectic, there is constant need for revision: "That is what I thought was happening, but now I find this. What is the relevance of this finding to the literature? What can I now say and is it still important?" This double conversation between self and data and self and literature needs to go on constantly. It is a version of grounded theory (Porpora 2015, p.215)

Weick (1989, p.516) described theorising as "disciplined imagination", as it requires both the consistent application of selection criteria to trial and error thinking and the deliberate introduction of diversity to problem statements. Danermark et al. (2002) also invoked the idea of moving between logical and more creative reasoning to enable shifts in thinking from a concrete situation to the abstract and back to another concrete situation. Rather than a bias to be removed, this intellectual interpretive work is crucial to the ultimate usefulness

of the study. As it involves "off-piste" work rather than a set formula, it needs the skills of an intellectual generalist who can negotiate meaning and refine questions in conjunction with real-world practitioners (Pawson 2006, p.179).

In a critical realist study, a researcher's multiple conversations with self therefore relate to empirical data, the research literature, and real-world practitioners. Shifting between insider/outsider, practitioner/researcher dimensions (1.3.3) also demands internal conversations. To this can be added conversations with self that relate to what is likely to resonate with desired audiences for the research. In constructing a sociology of the interesting, Davis noted "an intense familiarity with previous audience assumptions about the data" is necessary (1971, p.337) for a researcher to imagine whether what they choose to highlight is likely to provoke the desired reflective response of "that's interesting!" (rather than a dismissive "that's obvious!", "that's irrelevant!" or "that's absurd!" (Davis 1971, p.237)).

The strategy of abduction similarly calls for imagination and creativity as well as rigour.

2.2.4.2 Abduction

There are multiple and overlapping ways of sorting (classifying) the social world. This is a constant human activity; from any specific activity or event, we draw out generalities that help us make sense of it in relation to other experiences, and anticipate what might happen if we act in a certain way. Sorting is also a necessary human activity; it helps us organise our own and others' everyday lives, make priorities, and decide what is worth paying attention to and what we can ignore. The capacity to classify the social world is therefore part of people having agency. In turn, the way things are classified for us also structures our lives, often in invisible ways. The ubiquitous and taken-for-granted nature of classification may mask its political dimension and consequences:

> …each category valorizes some point of view and silences another. This is not inherently a bad thing - indeed it is inescapable. But it *is* an ethical choice, and as such it is dangerous - not bad, but dangerous. (Bowker and Leigh Star 2000, pp.5-6)

As a research strategy, abduction involves creative and critical re-sorting of the social world to see part of it in a different way, opening up the possibility of noticing connections that would previously have been invisible. Through abduction, an empirical event (outcome) can be redescribed, recontextualised or recast (tested) in different frames of interpretation (sets of ideas) to produce new but always fallible insights (hypotheses) about how things in the social world are structured and related (Danermark et al. 2002). Abduction depends on layered interplay between theory and empirical work, and therefore on establishing "how social actors view and understand that part of their world of interest to the researcher" (Blaikie 2009, p.90). This includes the concepts they use, the meaning they have attached to these concepts, and how they understand their own and others' social worlds.

Abbott's recontextualising of professions as predatory (1.3.1) is an example of abduction that meets Davis's criterion of "that's interesting!" (2.2.4.1) for a speech and language therapy audience. In chapter 4, I will show how the less dramatic insights from abductive and retroductive (2.2.4.3) strategies in this thesis were dependent on progressive sorting and framing of data and ideas using visual models.

2.2.4.3 Retroduction

Bhaskar proposed that what exists causally in the social world is stratified (mechanisms coming together to generate events, giving rise to experiences), with these layers brought into sync by social science (2.2.2). Retroduction as a strategy involves working backwards from empirical data (outcomes) to an explanation of the combinations of context and mechanism that made this outcome possible (Blaikie 2009); this depends on having access to information about these relationships over time (O'Mahoney and Vincent 2014). Retroduction asks what foundations, circumstances or conditions of the social world are necessary or contingent for particular concrete events to have happened (Danermark et al. 2002). A researcher is retroducing when they ask what the social world must be like for their findings to have occurred, and what it must be like for their non-findings not to have occurred (O'Mahoney 2016).

To put this into practice, Blaikie (2009) suggests the researcher imagine, model and seek evidence from data and their knowledge of social processes to support or refute proposed explanations. For Danermark et al. (2002), retroduction can involve the researcher drawing on their own social experience, selecting cases strategically (such as those which break norms or are extreme examples), and challenging the taken-for-granted. Fundamentally, they argue retroduction is about applying imagination to counterfactual questions:

> We ask questions like: How would this be if not … ? Could one imagine X without … ? Could one imagine X including this, without X then becoming something different? In counterfactual thinking we use our stored experience and knowledge of social reality, as well as our ability to abstract and to think about what is not, but what might be. (Danermark et al. 2002, p.101)

Like abduction, retroduction continues the ongoing conversations with self discussed in 2.2.4.1. For O'Mahoney (2016), reflexivity when retroducing is essential so the researcher questions their own assumptions rather than relying on them uncritically.

Being explicit about assumptions enables researchers to reflect on and refine them, and makes the logic of their study available for external critique. In the following section I show how exploring assumptions included asking critical questions about what must exist in the social world for practice change to be possible, and what kind of framework would give the best opportunity to develop a convincing explanation for practice change to have occurred as it did.

2.3 Theory structure

Sociological theorist Margaret Archer (2014) argues that all theories about the social world have a three level structure (Table 2-1), whether or not the person proposing them is aware of or makes this structure explicit. The first level, social ontology, regulates the concepts which are acceptable and necessary to a particular social science study. This social ontology explains nothing in itself, but helps the researcher decide what needs to be incorporated in the second level, the explanatory framework. The explanatory framework proposes how these most relevant concepts are related, thus opening up a space to develop

the third level, a practical social theory. As the label suggests, this should be a useful, workmanlike explanation about a particular aspect of the social world.

Table 2-1: Structure of social theories (after Archer 2014)

Social Ontology	Explanatory framework	Practical social theory
• Defines what constitutes the social world • Has a governing role on the concepts that can be used in description and explanation of the social world • Does not say anything about how to use these concepts to explain the social world • Does not provide an explanation	• Posits how the concepts that can be used in description and explanation of the social world are related • In this way, provides a framework for going about explaining an aspect of the social world • Does not provide an explanation	• Working with a research question within the explanatory framework, the job of a practical social theory is to explain a particular aspect of the social world

In the following sections I use Archer's typology to make the structure of social theory in this study explicit. In 2.4.2 I show how sensitising theories provided a further level of structure between the explanatory framework and the practical social theory.

2.3.1 Social ontology: ontological realism

My critical realist perspective on the research terrain of this study gave priority to ontological realism, social constructionism, and acknowledging fallibility, the existence of structure, agency and multiple contingent conjunctural causality, and the importance of human flourishing. Any explanatory framework had to incorporate these concepts. As my research question entailed a design that allowed for exploration of practice change in a single professional group over time, this framework also had to account explicitly for culture, and for the dimension of time.

2.3.2 Explanatory framework A: the Morphogenetic Approach

An explanatory framework takes the concepts that are more relevant to the research interest (social ontology, 2.3.1) and posits a relationship between them. While not in itself explanatory, this relatively generic meta-theoretical framework creates a space within which a researcher can develop particular explanations through empirical work.

Archer's Morphogenetic Approach is a critical realist explanatory framework designed to offer a "tool kit for developing the analytical histories of emergence of particular social formations" (Archer 2010, p.274). It is underpinned by a number of assumptions relevant to my research interest:

- change is a social process which happens whether or not people are aware of the mix of mechanisms at play
- people have concerns in relation to the world, and agency to act on these concerns to shape society
- social structures shape society, and are more enduring than the people who inhabit them
- culture as the distribution of ideas also shapes society and - in terms of endurance over time - parallels social structures
- the interaction of Structure, Agency and Culture (SAC) explains the emergence (or not) of social change
- social change is on a continuum from transformation (morphogenesis) to reproduction (morphostasis) of an existing system, with these extremes occurring rarely

In framing how and why social change happens, the Morphogenetic Approach has a key distinguishing characteristic: the principle of *analytical dualism*. Archer posits that structure, agency and culture shape and constrain each other, so are in a dialectical (conversation-like) relationship. However, as they have independent existence and different time frames, they are not reducible to each other. In developing a practical social theory about the transformational / reproductive powers of their interplay, the researcher therefore treats agency, structure and culture as analytically distinct.

As long-term abstract sociological constructs, agency, structure and culture mean different things to different people. To carry the principle of analytical dualism forward practically, it was important to have working definitions which I could refer to and refine. These were heuristic and influenced by a range of authors.

2.3.2.1 Structure: working definition

Social structure refers to the patterned ways in which people in a society are connected both to each other and to social resources. Structures pre-date particular individuals, setting (but not determining) the conditions and context for their social life and opportunities. These dynamic conditions, whether noticed or unnoticed, can have enabling, motivating or constraining causal effects on human behaviour, because they place people in relation to each other (social positions such as manager/therapists, therapist/clients, mother/children) and to social resources (such as modes of communication, education, healthcare, money, time) in ways that are more or less equal / unequal or reciprocal / exploitative.

Social structure is an abstract concept, made more concrete in institutions such as the NHS, schools, family units and professions. Specific relations within and across structures are diverse, ranging from those that emphasise conflict ("competition, dependency, power, inequality, and the like" (Porpora 2015, p.197)) to those that emphasise integration (love, friendship, trust, involvement, care, respect) (derived from my reading of Donati 2011, pp.90-91). As social structures have been made and reproduced by humans collectively, they are relatively enduring, but have the potential to undergo even radical restructuring (Archer 1996).

2.3.2.2 Culture: working definition

Culture refers to "the relations pertaining between ideas and the ideational influences operating between people" (Archer 1996, p.xiii). The cultural resources at people's disposal were there before them and were not of their making, but shape and constrain how they make sense of and respond to the world. Culture is a relational concept, both because an idea is *about* something, and because it is connected to other ideas, whether tightly or loosely. Culture

also refers to ideas as collective (a property of groups) rather than individual (a property of a single mind). However, culture is less about shared ideas uniting and differentiating a group from other groups than about how ideas are *distributed* (Maxwell 2012). Diversity of ideas - variation, connection and interaction within and across groups - is therefore vital to an investigation.

Culture includes the products of people's minds (such as books, theories or therapy materials), which have the potential to be influential on other people's ideas and behaviour, whether or not this is what the producer intended. The cultural context includes language, rules, myths, ideologies, rituals, stereotypes, morals, the taken-for-granted, feelings, mood, experiences and values (concerns, passions, commitments, ideals, interests, preferences) that, whether noticed or unnoticed, thought about or not, have causal effects (Porpora 2015). Like social structures, culture is relatively enduring because it is made and reproduced by people over time, and it has the potential to shift, even radically, depending on what people contribute to its modification.

2.3.2.3 Agency: working definition

Individual people - as ontological beings with an enduring self - feel, think and negotiate their life in relation to the world. They are born or inducted into structural and cultural systems which pre-date and may outlast them. These conditions have causal effects on their lives; however, such conditions do not determine their lives and actions, because causal effects can only be activated where human projects (agency) exist:

> Only because people envisage particular courses of action can one speak of their constraint or enablement, and only because they may pursue the same course of action from different social contexts can one talk of their being differentially constrained and enabled (Archer 2003, p.4).

Agency is the extent to which a person exercises their choice to act (or not act) to make something happen, to deal with something that has happened, or to give priority to one concern over another. It involves intention, purpose and caring about something - in other words, having reasons for what you do. Although people have agency, they may be more or less able to experience and express it in relation to structural and cultural conditions.

The actions of agents in the past shaped the structural and cultural resources available now, and the actions of agents now will do the same for their successors because:

> As actors twist and turn and otherwise act within the structures that bind them, they modify those structures (Porpora 2015, p.104).

2.3.2.4 Relating agency to structure and culture

Agency involves intention, but problematic situations which have moral dimensions and considerable uncertainty - such as speech and language therapy intervention - demand considerable reflection on intentionality. For Archer, this happens through internal conversations (2003), in other words self-talk or personal reflexivity about the potential consequences of different courses of action for self, for society, and for the relations between them. In speech and language therapy this is already recognised through the emphasis on reflective practice as part of continuing professional development (HCPC 2012).

However, Archer posits that, while agents have always had to face the unknown or unscripted, this has increased because we are living in an age of unprecedented morphogenesis between the cultural and structural domains, with variety stimulating more variety (Archer 2012). Structures are still relatively enduring but their timescale is becoming shorter, so the scope for routine action is reducing. This means there is greater need for collective as well as personal reflexivity.

2.3.3 Explanatory framework B: complex interventions

I was drawn to Archer's Morphogenetic Approach in the early stages of this thesis, as it was a broad explanatory framework that enabled me to account for the reality of clinical practice rather than imposing boundaries. During the primary study, it became clear that this reality included intervention for children with SSD as a thing with recurring elements that appeared to be layered, interacting and open to change. I therefore looked to the complex intervention literature to help me construct a more targeted explanatory framework.

In the applied health research field, 'complex interventions' have a number of interacting components, depend on particular behaviours of those offering and receiving them, have a variety of intended outcomes, and are intended for

flexible use according to individual need (Craig et al. 2008). Arguing that the idea of components of complex intervention is frequently discussed but rarely defined, Clark (2013) theorised seven approaches. These differed by whether an intervention was seen as a single entity, component parts, higher and lower order parts, or parts and a whole. In addition they differed by whether these parts were treated as non-existent, irrelevant, or important in terms of powers to influence the outcome.

Four of these approaches are compatible with a critical realist perspective, as they pay attention to what exists in an intervention and are underpinned by an assumption of contingent conjunctural causality. Rather than choosing and applying one of these approaches, I used the ideas embedded in Clark's typology and the methods in chapter 4 to develop a model of changeable SSD intervention elements.

2.3.4 Practical social theory: working with the research question

The third level of theory structure after social ontology and the explanatory framework is a practical social theory, working with the research question:

> to explain why things structural, cultural or agential are so and not otherwise, at a given moment in a given society (Archer 1995, p.344)

As a heuristic, Archer's basic morphogenetic sequence can support this process (Table 2-2). It has four time points, which differ for structure, culture and agency through the principle of analytical dualism (2.3.2) (Archer 1995). T4 is at the top because using the idea of a morphogenetic sequence usually involves working backwards. This includes retroducing (2.2.4.3) from how things are at the selected moment in the chosen part of the social world to the conditions and circumstances that made this possible.

Table 2-2: Basic morphogenetic sequence (after Archer 1995)

Point	Description
T4	Identification of an outcome / problem that sets the context for successors
T3	The (arbitrary) end of the period of action related to this outcome / problem
T2	The (inferred) start of the period of action related to this outcome / problem
T1	The context that moved people to action at T2

Applying the idea of morphogenetic sequences to my research question involved identifying T4 (practice change) and tracking back to T1 (what practice had been, and why this could not continue). How I went about this was informed by 2.4 and is detailed in chapter 4.

2.4 Case-based sociological inquiry

My aim with this study was to explain how practice had changed and why there were different trajectories - cases - of change. However, I faced many unknowns, most notably what might constitute a case. I could draw on my experience, contacts and social media to make informed guesses, but was largely progressing on the assumption that:

  i.   practice changes would have occurred
  ii.   there would be multiple and varied examples
  iii.   these changes would, to a greater or lesser extent, be patterned within and across therapists and contexts

Pre-specifying these cases, or the boundaries of their contexts, would have risked overlooking less obvious properties and interdependencies that had nonetheless made an important difference to the outcome (Sayer 2010). It made more sense to configure, reconfigure and perhaps even transform the cases of practice change over the course of the study, taking account of differences that appeared to have made a difference. Ragin calls this inductive and flexible research tactic for delimiting the empirical world "casing". Although a routine activity of social science, casing:

> is selectively invoked at many different junctures in the research process, usually to resolve difficult issues in linking ideas and evidence. (Ragin 1992, p.217)

My job was to design a case-based sociological inquiry that would both identify real-world cases of practice change and offer a best explanation of how these outcomes had come to be. The design components were a primary study, sensitising middle-range theories, and a qualitative synthesis.

2.4.1 Primary study

My emphasis on human agency and flourishing brought two assumptions to the design of the primary study. The first was that speech and language therapists' practice would really matter to them. The second was that they would have thoughts and internal conversations about what they do (or don't do) and what they could do (or not) instead, and that these would have causal powers in relation to practice change.

In deciding to ask speech and language therapists for first-hand accounts about how and why they had changed their practice, I was treating them as ontological beings who reflect, are creative, and intentionally exert an influence on the world, whatever structural and cultural forces are brought to bear on them[12]. In practical terms, this meant trusting participants to choose the practice changes they wanted to talk about within the broad parameters of the study (past or present, major or minor, abstract or concrete), and to tell their stories (short or long, simple or complex) about these changes:

> Narrative is particularly apt, in fact, for showing the combined effects of structure, culture, and agency. On the one hand, the effects of structure and culture show up mainly in the thoughts and actions of individuals. But because those socially structured thoughts and actions remain creative, they do not necessarily follow regular patterns. (Porpora 2015, p.210).

In addition, to have the best chance of identifying and explaining cases of practice change, I decided to build in connections and diversity to the research design. Sayer (2010) argues it is important to ensure people or other objects of investigation have actual connections (not just similarities and differences), and the potential to be causal groups (i.e. the power to make particular things happen). Real connections can make the contribution of structure and culture to a state of affairs more salient to the researcher, and provide natural opportunities for corroboration to test and refine emerging theories.

I aimed for diversity to take account of the different significance that similarities and connections - as well as the research study and its questions - would have for different people because:

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[12] See discussion in Archer 2003, pp.9-14

> First, we need to better understand the diversity that actually exists within social institutions and societies, and to investigate the ways in which social solidarity and community are created and sustained that may not depend on the similarities between us. Second, we need to use methods for social research that do not presume commonality or similarity or impose an illusory uniformity on the phenomena we study (Maxwell 2012, p.51)

This meant being alert to configurations which existed and to those which did not, and exploring "the possible reasons for their absence" (Ragin 2000, p.76).

Given the number of known unknowns I had already built in to the design, I was reminded of Pawson et al.'s advice to seek balance in known knowns, known unknowns and unknown unknowns (2011). To give a realistic prospect of including causal groups, the sample I started with had to have sufficient similarities and connections within which I could make sense of its diversity.

Speech and language therapists have some homogeneity as the profession is overwhelmingly female and white (RCSLT 2002). In addition, all are educated as a minimum to degree level, and to practise in the UK must meet conditions of registration with the Health and Care Professions Council. Most are also members of the Royal College of Speech & Language Therapists, which supports professional development through a strategic plan and structures such as Clinical Excellence Networks. Within Scotland, there is homogeneity at a policy level, as all children's services operate within a whole-country well-being framework aimed at Getting It Right For Every Child (GIRFEC). Although there is flexibility for local implementation, the principles of early intervention, universal services, and multi-agency working across organisational boundaries apply (Coles et al. 2016). Finally, the majority of therapists working with children with SSD are community generalists. A survey of working and clinical practice of 516 paediatric speech and language therapists across the UK confirmed a common experience of working across several settings where most "must be confident treating different types of clients" (Pring et al. 2012, p.704).

Community generalist speech and language therapists are connected to each other as members of teams within services and geographical sub-divisions, and may also be connected through membership of local, national or virtual networks. They may have connections through sharing a base, or via

organisational roles such as management and leadership. Less obvious connections may exist and be causally important but cannot be pre-specified; these include therapists who have studied, worked together or shared a particular experience in the past, or who are friends.

The first design component of the primary study therefore built in similarity, connection and diversity of participants and contexts. Attending to their frames of reference around practice change would be further enhanced by interplay with theory (2.4.2).

2.4.2   Theoretical sensitisation

To support the theory-generating purpose of this thesis, the second design component involved drawing on existing theories, frameworks and concepts as practical tools to sensitise me to connections that may exist but would otherwise go unnoticed. I did not aim to prove, test or refine these theories (May et al. 2014). Instead I sought to harness them in the sociological sense attributed to Herbert Blumer (Hammersley 2006) to identify what might be going on empirically that could help to explain the work and trajectory of practice change.

Adapting Archer's theoretical structure to make this level explicit, Table 2-3 shows how the implementation-practice-profession lens (1.2) fitted in between the explanatory framework and the practical social theory generated by this study. It also shows how there was room for other middle-range theories to be incorporated as empirical work proceeded. Normalisation Process Theory (1.2.1.4) and Practice and Practice Architectures (1.2.2.1) were most influential throughout.

Table 2-3: Structure of social theory (adapted from Archer 2014)

Social Ontology	Explanatory framework	Theoretical sensitisation	Practical social theory
Critical realism	Morphogenetic Approach Complex interventions as layered parts and wholes	Implementation-practice-profession lens	Theory of SSD practice change (chapter 5)

2.4.3 Qualitative synthesis

The third design component, a qualitative synthesis, is discussed in chapter 3. It aims to provide greater insight into the phenomenon of practice change in speech and language therapy than any primary study could do on its own.

2.5 From research design to research practice

In this chapter I developed a set of ideas about the most appropriate and useful methodology for investigating the research question framed in chapter 1. Critical realism infuses all aspects of the design, which has a practical purpose of configuring and explaining cases of practice change. In addition, the theoretical structure is explicit and therefore open to critique.

Before methods for the primary study are detailed (chapter 4), chapter 3 reports the methods and findings of the third component of the research design, the qualitative synthesis.

3 Synthesising qualitative research of speech and language therapy in practice

In chapter 2, I developed a set of ideas about the most appropriate research design for investigating the research question framed in chapter 1, 'How and why have speech and language therapists changed their practice with children with SSD?' The case-based sociological inquiry comprised three components: a primary study, sensitising middle-range theories, and a qualitative synthesis. This chapter explores the contribution of the qualitative synthesis.

The exponential growth in published primary research has focused methodological attention on the potential of research synthesis to provide greater insights than any single paper could do on its own, increase confidence in research findings, and reduce research waste. The diversity of primary research - and what is absent in a body of literature - presents both methodological opportunities and challenges for synthesisers (see Suri 2014) but, as critical realism is theoretically and methodologically pluralist, there is room to be creative. To meet its aims, this qualitative synthesis is a hybrid of realist sampling and meta-ethnography.

3.1 Aims and research question

Although a single professional group, speech and language therapists work in diverse settings (e.g. homes, clinics, nurseries, schools, wards, out-patients, rehabilitation centres, nursing homes); work with a wide range of professionals and multidisciplinary teams; have a variety of roles (e.g. universal / targeted / specialist); and serve many client groups. As a consequence, Abbott's observations on the interdependence of professions and shifts in jurisdictions (1.2.3) are as relevant within the profession as they are beyond it. I wanted to:

a) learn from how other researchers had approached this terrain (how and why speech and language therapists have changed their practice)

b) use relevant empirical evidence to provide context and theoretical sensitisation for my primary study

    c) pay particular attention to jurisdictional tensions within the profession, as my primary study was focused on only one (SSD)

These aims were best met by sampling qualitative primary research papers. In configuring any review of qualitative work, it is important to consider what appears to be available and what does not. My familiarity with the literature and clinical practice suggested that framing the research question around 'change' or 'implementation' would limit the potential to generate new understanding around practice change compared to a broader question about 'practice'.

It is also important to consider the historical circumstances in which primary studies have been conceived, conducted and reported. Although the profession's work has rightly been described as an "epistemological hybrid" (Bench 1991, p.240), a content analysis of the 18 volumes of the International Journal of Language and Communication Disorders identified only 9.3% of papers as qualitative compared to 72% as quantitative (Armstrong et al. 2017, p.7). However, a critical and historical review of speech and language therapy research suggested experimental approaches influenced by behaviourism are reducing and:

> a slow but steady utilization and acceptance of qualitative and interpretive research has evolved as a response to questions addressing interactional phenomena and social action of various kinds (Damico and Ball 2010, p.3)

I was mindful that this historical culture would have shaped the topics, methods and content of available qualitative reports. I also wanted to give priority to the idea of human flourishing (2.2.3). I therefore decided to sample purposively studies of first-person accounts from speech and language therapists.

This decision-making process led to the research question for the synthesis:

How have speech and language therapists (P) explained (F) the work of their practice (Ph) in in-depth qualitative studies (D)[13]?

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[13] (P)=Population, (F)=Focus, (Ph)=Phenomenon, (D)=Design

3.2 Methodology: meta-ethnography meets realist sampling

In thinking through how the synthesis could best address this question, I brought together two sets of ideas. One was the critical interpretive approach of meta-ethnography (Noblit and Hare 1988; Lee et al. 2015) and the other realist sampling of cases in qualitative research (Emmel 2013).

The comparison work of a meta-ethnography is done on any small, purposively sampled set of qualitative accounts to show how they might be related (Noblit and Hare 1988). The underlying logic is of configuration rather than aggregation (Lee et al 2015); this echoes critical realist assumptions that explanation lies in multiple contingent conjunctural relationships rather than additive ones (2.2.2). In a masterclass with George Noblit (see summary in Nicoll 2016), the potential congruence of meta-ethnography with critical realism became even more apparent. Noblit is relaxed about how people put meta-ethnography into practice, as long as they are explicit about what they are doing. He prefers that meta-ethnography is used for interpretation and critique, and that the conclusions enable people using the findings to choose to do something more about their situation. He wishes the 1988 book had used the idea of storylines (rather than giving the impression synthesis should be literally of 'findings') and given more weight to reflecting on the historical contexts in which primary accounts were produced, as this would have encouraged synthesisers to contemplate connections and underlying mechanisms.

In terms of sampling, meta-ethnographies have moved away from Noblit and Hare's original idea of a small, purposefully sampled set of accounts. In a summary of common methodologies for synthesising qualitative health research, Tong et al. (2012) compared different reportable aspects including the literature search, which for meta-ethnography was "non-specified" (p.5 of 8). This effectively leaves three sampling choices (Figure 3-1): identify relevant studies and synthesise them all; identify relevant studies then reduce the sample before synthesis; identify relevant studies then reduce the sample through a synthesis process.

Figure 3-1: Sampling options for meta-ethnography
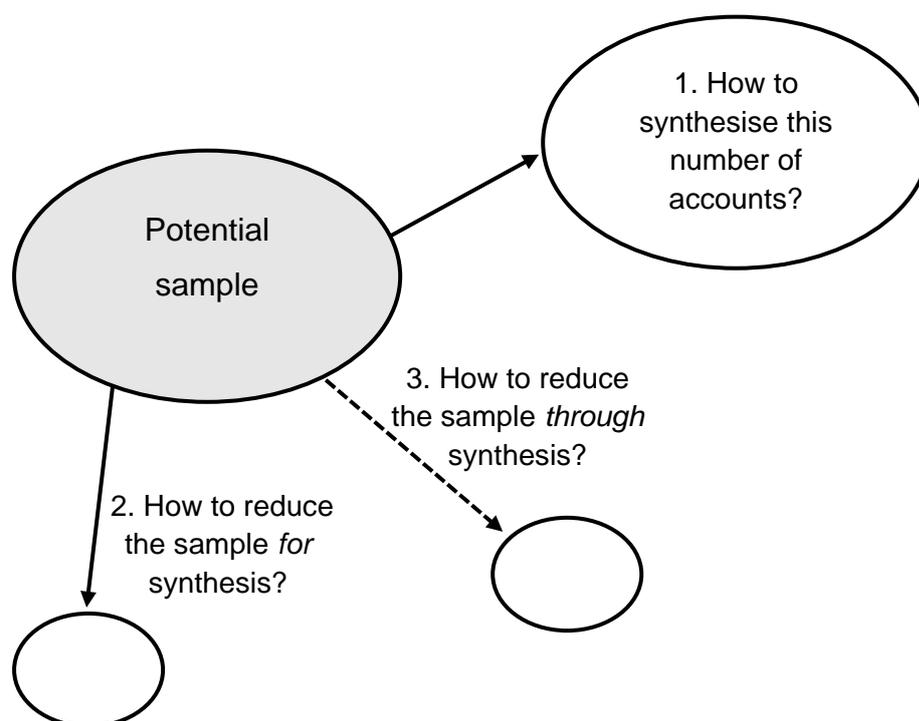
I felt the first option would need a less inductive research question. A number of researchers have taken the second option of conducting a systematic search, then reducing the sample for synthesis. Bridges et al. (2013) reduced 58 papers to 18 by weighting quality and only using those judged high quality. Grant et al. (2014) purposively reduced 28 papers to 16 through organising them according to themes and selecting those of the highest quality in each. Ring et al. (2011) had 20 papers meeting their inclusion criteria, but judged only eight sufficiently rich conceptually to inform the synthesis.

For my exploratory aims, making a priori quality judgements did not seem appropriate. Instead, I decided to apply and test a realist sampling approach which Emmel (2013) outlined for primary qualitative studies. Rather than defining then synthesising a sample, the process of defining it - including compromises to make it practicable - would be part of the ongoing, reflexive, interpretive and theory-refining work of the synthesis.

As meta-ethnography is an iterative and emergent way of generating knowledge, the outcome is inherently unpredictable, and synthesis is not

always possible (Lee et al. 2015). Taking this hybrid approach meant the sampling process was itself a synthesis; I therefore could not know whether further synthesis beyond that point would be either possible or useful.

3.3 Methods and initial findings

3.3.1 Systematic search

Given this was an original study, I developed a systematic, explicit search strategy to reduce the likelihood of missing relevant papers and to ensure it could be reproduced or refined. It developed iteratively in five main ways:

1. Familiarity with the literature, its location, and what might be do-able
2. Generating terms - including synonyms and logical word groups - to consider the **P**opulation, **F**ocus, **Ph**enomenon and **D**esign dimensions of the research question (3.1) using Coggle mind-mapping software
3. Working backwards from articles identified informally, serendipitously and through pilot searches to identify a search strategy which would have found these papers. Using an Excel spreadsheet, I took account of the terms themselves, where they appeared within a publication (title, abstract, full text), and which databases indexed these journals. This structured backwards chaining approach was based on 23 papers, 21 of which were completely relevant. Two almost relevant papers were included to increase confidence in the strategy's sensitivity.
4. Attending a day's training about developing search strategies, including the idiosyncrasies of different databases
5. Experiential learning from a dry run of searching, deduplication of records and screening using liberal exclusion criteria, with any uncertainties discussed informally with a colleague experienced in conducting systematic searches.

To set boundaries that would increase specificity (relevance of identified records) while keeping control of sensitivity (not identifying too many irrelevant records) of the search, I constructed the strategy around the **P**opulation (speech and language therapists) and **D**esign (in-depth qualitative studies) elements of the research question. Many terms used in speech and language

therapy practice are also used in qualitative research (e.g. conversation analysis, discourse analysis, narrative). Given the review was about perspectives of people who are speech and language therapists - and that this title and its variants are protected in many countries - it made sense to look for qualitative research terms along with the 'person' rather than the 'profession'.

I made three pragmatic choices. Firstly, to focus on identifying the most in-depth qualitative interpretations of therapists' perspectives across a breadth of practice, two types of exclusion applied: studies using mixed populations or mixed methods, and non-peer reviewed practice magazines[14]. Secondly, unless compelling reasons to be more inclusive emerged, the search would focus on electronic databases. Qualitative research has a short history in speech and language therapy, and has mainly focused on clients. Internationally the profession is a relatively small, connected community that has hitherto shown few signs of engagement with publishing in the wider social science literature. Studies of *therapists* (as opposed to *therapy*) were likely to appear in a limited range of journals and to be indexed with structured abstracts. The final pragmatic choice was to identify but exclude non-English papers and PhD theses. Funds were not available for translation, or for purchase of non-electronic PhD theses. Moreover, unless the identified group of studies was very small, it would not be practical to include whole theses.

The searches were carried out on 6th January 2015[15]. Weekly alerts were set up on each platform, and any newly published citations emerging through these or journal contents alerts over the following month that appeared to meet the screening criteria were incorporated.

In EBSCOhost, the databases PsychINFO, CINAHL with Full Text, Heath Source: Nursing / Academic Edition, MEDLINE, ERIC, Education Abstracts (H.W. Wilson) and the British Education Index were searched concurrently as no MESH terms were included. No limits were placed on this search. An Ovid MEDLINE search was available from 2010, and included MESH terms. Scopus was searched in Health Sciences and Social Sciences & Humanities, with no

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[14] This decision was based on my extensive familiarity with practice magazines
[15] Search strings available on request

other filters applied. The only profession-specific database, speechBITE, was not searched, as it does not index qualitative research.

EBSCOhost produced 1359 citations after some automatic de-duplication, Ovid MEDLINE (from 2010) generated 245 and Scopus 948, giving a total of 2552. All found citations were transferred to RefWorks software, with the results from each database placed in a subfolder. Each subfolder was saved for export in tab delimited format, then copied and pasted into Notepad software. Excel software was used to import the data from each text file into a spreadsheet. After checking all headings matched, the contents of the three spreadsheets were amalgamated (using 'paste values and source formatting'), extraneous columns deleted, and columns rearranged to facilitate screening. The records were sorted alphabetically in several fields to enable efficient de-duplication. This left 1659 records. Added to this were one known citation from a non-indexed tele-rehabilitation journal found on page 1 of a Google search, one from the review search alert and two from journal new contents alerts (subsequently also received in the review search alert). This totalled 1663 records for screening.

3.3.2 Stage 1: Screening

A spreadsheet was used to answer two Stage 1 screening questions for these 1663 records at title/abstract and, if necessary, full text level:

1. Is it solely about the perspectives of speech and language therapists?
2. Is it solely reporting qualitative research into these perspectives?

A simple traffic light system was visually helpful. In the spreadsheet, two cells had to turn green before a record would be included. Amber indicated a query or uncertainty, and any red meant the record would be excluded. Only a 'yes' to both questions would lead to inclusion at Stage 2. As I screened the records and resolved dilemmas, I made notes on inclusion/exclusion to clarify the decision-making process for a second reviewer, Linda Armstrong (LA), also a speech and language therapist and researcher. All records were transferred to a customised Access database, and a screening version given to LA with guidance and a flowchart. LA then screened the records independently.

LA and I met (20th February 2015) to discuss decisions which were not in agreement. Two were because I had missed out an exclusion criterion (clinical tutors) in the guidance. The other 10 were resolved through discussion. By the end of the Stage 1 screening, two further duplicates had been removed, 1576 records had been excluded at the title/abstract level, and 26 after getting further information from full text. Four citations which met the criteria were excluded due to translation costs (two German, one Portuguese and one French), and two because they were PhD theses[16]. This left a total of 53 records for Stage 2 (realist sampling).

3.3.3   Stage 2: Realist sampling

The systematic search in 3.3.1 had concentrated on the **P**opulation and **D**esign elements of the research question:

How have speech and language therapists (P) explained (F) the work of their practice (Ph) in in-depth qualitative studies (D)?

Realist sampling shaped the more abstract elements of **F**ocus and **Ph**enomenon.

As there was no theoretical reason to read the 53 papers in a particular order, I started reading the full text of all the papers alphabetically, making unstructured notes for each that might spark sampling choices. Around half way through, I brought more structure to the process, constructing a table to manage the notes, and continuing from the point I had reached in the alphabet before returning to the beginning. The table reflected ideas within the papers relevant to my aims, as well as how the ideas appeared to shape or be shaped by the data generated. These ideas did not necessarily correspond with any explicitly stated intent of the original authors.

Having started with a Word table, I realised the traffic light system from Stage 1 could be adapted to scaffold the more complex sampling choices I was now making. The scaffolding table was not fixed from the beginning, but comprised

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[16] One of which had produced an included paper

sections that I moved around, removed or erected as I went along; the categories therefore shifted and changed, not just their content.

Green, amber and red sections indicated respectively whether a particular concept appeared highly relevant, might turn out to be important theoretically, or could justifiably be excluded. I considered each paper in relation to the scaffold, writing justifications in the appropriate cells of a working table. As nuances arose, I continued amending the content and colours of the scaffold and the working table, checking periodically whether this would change preliminary decisions for previously considered articles. The process of choosing the sample was therefore iterative, but then applied systematically. Over time, I found it useful to shift the actual data into three working tables. One was for red (automatically excluded) papers. A second was for green + amber (included) papers and a third for green + amber (excluded after further developments in thinking).

Although the traffic light system could appear as if it were a product or checklist, it scaffolded the flow of ideas. The model in Figure 3-2 attempts to show how this unfolded. First, it became increasingly clear that a focus on actual experience mattered. This seemed to occur when studies focused on practice as a process, and when discussion included particular cases (clients or examples), so these became green categories. Understanding this made it easier to notice the range of reasons why some studies mattered less for this synthesis, and these became the red categories.

Figure 3-2: Model of realist sampling process
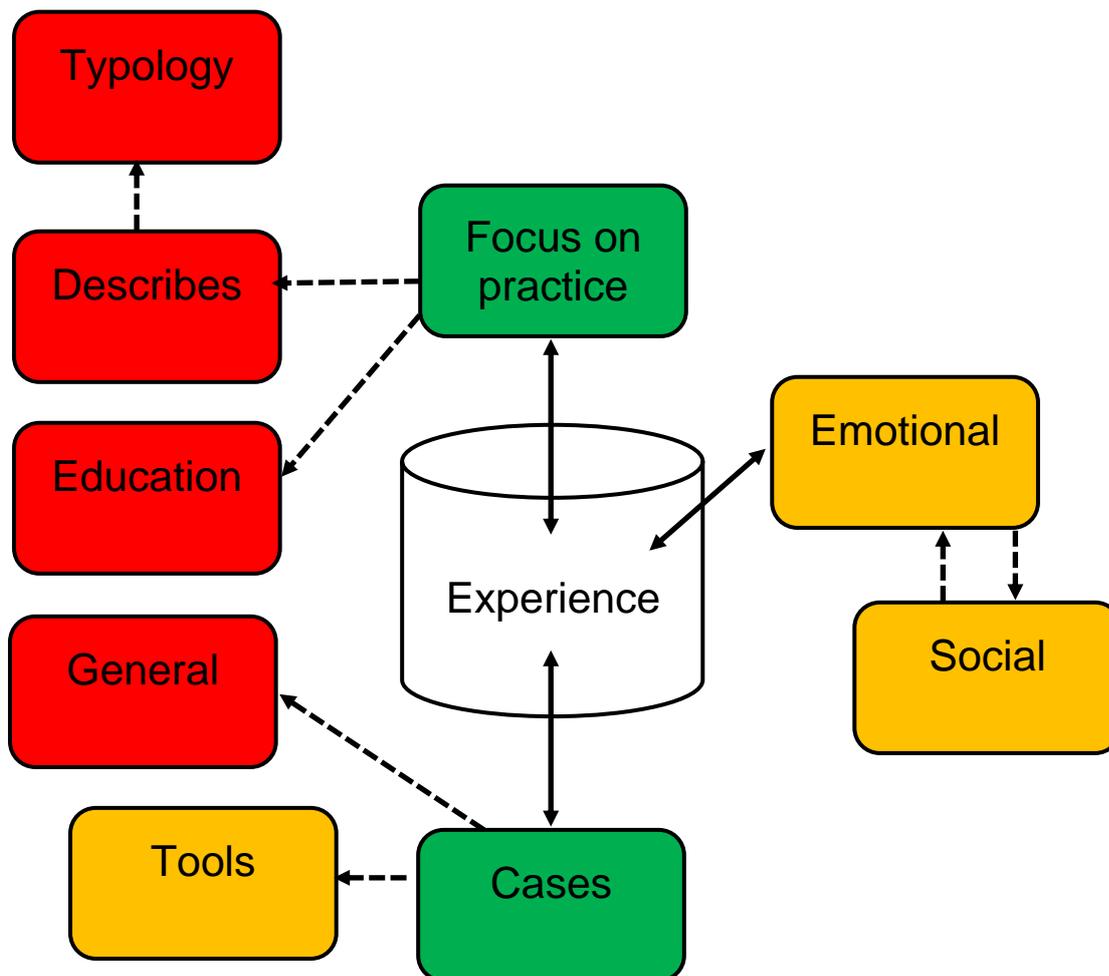
It also became apparent that amber, which I used for the more fragile ideas (Emmel 2013), was a crucial indicator of the need to pause and pay attention rather than move forward or impose a premature halt. One amber category (for studies focused on a 'tool' or 'thing') was originally subsumed within the green specific focus category. It was split into two green categories ('cases' and 'tools'), before I changed it to amber, then ultimately excluded these studies because their relative relevance had diminished as the process unfolded.

In contrast, it became increasingly clear that the type and depth of feelings expressed by participants helped me to understand their experiences of practice and change - but that this was tightly connected to how the researcher enabled participants to express emotion and thought it worthy of reporting. In addition, I had anticipated the social dimension of practice would be important

but saw little explicit exploration of it. At the time, I wondered if this was reflective of the general invisibility of applied theory in the study designs. However, later in the process (18th April 2015) I noticed an included paper was highly social. I questioned whether I had simply been unable to see the social because it infused the papers or if, being preoccupied with the emotional, I had conflated them. I therefore kept two amber dimensions (emotional and social) in the model.

Stage 2 (realist sampling) had three phases. In stage 2a I excluded 27 papers because they sought one or more of: a snapshot of practice; hypothetical or prospective views; to construct a typology; a focus on undergraduate or continuing professional education. In stage 2b I excluded five papers on the grounds they focused on implementation of a tool or intervention rather than on practice. Continued analysis and / or discussion with LA revealed a further five papers should have been excluded under these criteria (stage 2c).

Ongoing discussion with LA was essential in helping me understand I was drawn to retain some papers because I found them interesting rather than because they met the criteria I was developing. These discussions included a quality dimension; for example, I was unsure about one paper but wanted to keep it in because it covered rural practice, an otherwise unrepresented client group, and social aspects. However, LA pointed out not only that its *prospective* focus fell outside the criteria but that the reporting and methods were questionable.

The place of quality appraisal in a qualitative synthesis is a matter of debate around whether, how and when it should happen, and how its findings should be used. Reflecting on their changing views of quality appraisal over the course of a meta-ethnography, Toye et al. summed up the dilemma:

> methods alone do not determine the quality of research for inclusion into a meta-ethnography. Concepts that facilitate theoretical insight are the raw data of meta-ethnography, and arguably, are integral to the quality of research. However, to be judged 'good enough' we suggest that there needs to be some assurance that the interpretation presented is more than simply anecdotal. (2013, p.11)

Through the realist sampling, I unpacked critically how each paper under consideration contributed to the developing model. I found it useful to bear in mind Tracy's (2010) heuristic: that eight 'big tent' criteria for excellent qualitative research (worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethical, meaningful coherence) can be universal ends reached by different means. An additional quality appraisal step therefore seemed unwarranted. Quality considerations were not ignored, but dealt with pragmatically when encountered and important in relation to the developing sample. For example, I twice looked up electronic PhD theses associated with papers. In one this was to address a reporting quality problem (necessary tables which were referred to but missing from the paper). In another, I was concerned by the size of focus groups, and wanted reassurance about how they had been conducted to generate the data.

The full search and sampling process is recorded in a modified PRISMA (2009) flow diagram (Figure 3-3). The realist sampling approach reduced an initial sample following screening of 53 papers to 16 through a synthesis process. Deciding when to stop sampling was a judgement, as it would have been possible to continue refining the model (Figure 3-2) and the rationale (Table 3-1). How this rationale relates to the final green + amber (included) studies is in Table 3-2.

Figure 3-3: Modified PRISMA flow diagram (2009)

Records via database searches 6/1/15

EBSCOhost (7 databases) n=1359

Ovid MEDLINE (from 2010) n=245

Scopus n=948

Total n=2552

Additional records identified:

Search alerts (13/1/15) n=1

Google (non-indexed journal) n=1

Journal alerts (by 6/2/15) n=2

Total n=4

Records after duplicates removed

n=1659

Stage 1 Screening (3.3.2)

- Is it about SLTs' perspectives?
- Is it qualitative research?

n=1663

Records excluded (relevance)

Duplicates n=2

Title/Abstract n=1576

Full text n=26

Records excluded (pragmatic)

Dissertation n=2

Not in English n=4

Stage 2 Realist sampling (3.3.3)

n=53

Records excluded

Stage 2a n=27

Stage 2b n=5

Stage 2c n=5

Stage 3 Final sample

n=16

Table 3-1: Rationale for realist sampling scaffold

Category	Why?	Because
Practice change	Focused on lived experience of practice change / implementation (underlying 'process' approach)	• The people who change their practice have the most experiential knowledge to share. • The experience of these agents offers a window into the structure-agency-culture realities shaping and being shaped by practice.
Cases	Seeks 'how' and 'why' reflection on experience through specific cases (people or events)	• The narrative developed around memorable cases will have shaped future practice. • Reflection on specific, memorable events facilitates inclusion of subtle contextual detail such as tacit knowledge. • Clinicians using the research will be more able to relate to the findings and consider 'how, when and why might this apply to me?'
Emotional / Social	Explicitly admits the social and / or emotional dimensions of practice	• Emotional and social dimensions of experience shape the sayings, doings and relatings of practice, but are under-explored in the implementation literature generally.
Tools	Seeks 'how' and 'why' reflection on experience through a specific thing (practice, intervention or tool)	Similar arguments to reflection on specific cases apply, but with the following caveats: • The implementation imperative may be perceived by agents as external and top-down, and therefore less relevant than one associated with a memorable case. • Practice change may not be a priority if there are stronger competing demands, or if the chosen intervention / tool is not relevant to the needs of the caseload at the time.
Describes	Focused on a description of practices, strategies or experiences (underlying 'snapshot' approach)	• Uncovers the technical, logical process of practice but not the emotional dimensions. • Less likely to be of explanatory value in relation to practice change.
General	Seeks general, hypothetical or prospective views on practice or associated topic (e.g. perspectives on clients rather than SLT role)	• Although this may draw on specific experiences, there is more scope for generalisations which lack contextual detail and tacit knowledge.
Typology	Has an underlying typological purpose (that is not specifically about how the event was experienced)	• Will privilege the categorisation and activity over the experience.
Education	Has a focus on undergraduates, new graduates, curricula or formal training	• In the context of a career, 'practice change' implies it was previously done differently. • In the allied health professions training is the most common strategy to encourage practice change, but on its own it is ineffective.

Table 3-2: Final sample as scaffolded

Study no.	Practice change	Cases	Emotional / Social
75	Working on an intensive comprehensive aphasia program	Specific experience	Specifically asks what the effect is on clinicians
289	Recognising children with potential autism in primary care	Experiential accounts	Focused on the experience
407	Supporting communication intervention for students with multiple and severe disabilities	Experiential accounts	Focused on the experience
510	Aphasia practice in acute sector	Experiential accounts	Focused on perceptions and beliefs
608	Process of including significant others in aphasia rehabilitation	Accounts including imagined 'ideal'	Focused on perceptions and imagined ideal
648	Stories of ending the therapeutic relationship	Stories that stick in the mind	Unusual or extreme events or feelings that shape practice
655	Narrative – work with indigenous Australians with acquired communication disorders	Experiential accounts	Through the stories
668	Shift in clinical paradigms in aphasia practice	Auto-ethnography	Specifically 'explores the emotional aspects of a shift in therapeutic ideology and clinician role'

704	Implementing AAC as part of early childhood intervention	AAC not conceived as a 'tool' but as an integral part of therapy provision for this group	The 'burden' on clinicians addressed explicitly in discussion
779	Experienced therapists' responses to ethical dilemmas	Narrative accounts	Described as going beyond critical incidents to sharing their professional stories
971	Working with SLT assistants	SLTs / assistants paired for research study	Intrinsic rewards
1282	Implementation of an inclusive collaborative classroom-based service delivery model	One SLP's successful practice – how did she do it?	What's 'hard'
1574	Experience of being a speech and language therapist	Focused on personal experience in context	A 'being connected' theme
1674	Actual reasoning for clinical decisions (vs assumption of scientific)	Complexities and paradoxes of practice described by SLTs	Attitudes underpinning treatment choices and therapy process
1676	Clinical practice (aphasia)	Not just how it is, but how it has changed over time	Comes through alongside description of activity
1677	Experience of EBP in acute aphasia management	Personal experiences and perceptions	Finding of 'disempowerment' – arose strongly and to a greater extent than expected – very strong feelings / body language

3.3.4   Stage 3: Describing the sample

The realist sampling approach led to a group of 16 papers which had conceptual coherence in relation to the aims of the synthesis (Table 3-2). All had been designed in a way which enabled participants to:

1) Talk about the realities of their practice over time
2) Illustrate this through discussing specific cases or instances
3) Reflect on the emotional work involved.

Table 3-3 summarises the authors, year, journal, aims / research questions, design, sample, country (of participants), and area of practice for each of the 16 papers. The sample included two examples of the same dataset underpinning two different papers; in addition, one author (Linda Worrall) had contributed to a third paper. Eight papers (six datasets) were located in Australia, and eight (six datasets) related to clinical practice with people with aphasia. Publication ranged from 2005-2015, with nine published in 2013-15, six of which (five datasets) related to aphasia. The 16 papers were distributed through 11 journals, with the International Journal of Language and Communication Disorders having most (three).

In three papers, the data related to a single speech and language therapist. Each was for a good reason: an auto-ethnography; a rich interview selected purposively from a dataset for secondary analysis; and an instrumental case study. Sample size and composition was often influenced by practical constraints, and was not always well reported. However Hersh (2010) interviewed 30 speech-language pathologists, and Cameron and Muskett (2014) and Foster et al. (2015; 2014) used purposive maximum variation sampling and reported both the pool of respondents and the number interviewed. Unusually for qualitative research, McCurtin and Carter (2015) involved 48 speech and language therapists through just three focus groups.

Designs were primarily described as phenomenology (4), thematic analysis (4), grounded theory (3), case study (2), narrative (2), and auto-ethnography (1). Data gathering was primarily by interview (12), focus groups (1), a combination (2) and auto-ethnography (1). The authors of one paper (de Bortoli et al. 2014) specifically related their study to complexity theory.

Table 3-3: Final sample of 16 papers described

Author(s)	Journal	Aim(s) / Research Question(s)	Design	Participants	Country	Topic
Babbitt et al (2013)	Topics in Stroke Rehabilitation	The clinician experience of working in an intensive comprehensive aphasia program	Exploratory qualitative; phenomenological approach / analysis; semi-structured interviews (27-62 mins)	Purposeful sample 7 SLPs	USA / Australia	Intensive program (aphasia)
Cameron and Muskett (2014)	Child Care in Practice	SLTs' experiences in primary care of recognising that a child may have autism spectrum disorder	Small-scale qualitative; inductive thematic analysis; semi-structured interviews; experiential accounts	5 SLTs purposively sampled from respondent pool of 10	Republic of Ireland	Recognition and onward referral of children who may have autism
de Bortoli et al (2014)	Augmentative and Alternative Communication	SLPs' perceptions and experiences of supporting communication intervention for students with multiple and severe disabilities, and of supports and obstacles to implementation	Individual interview (45-120 mins, 4 open-ended questions) + follow-up focus groups; thematic analysis; complexity theory	8 SLPs in metropolitan area	Australia	Intervention for students with multiple and severe disabilities
Foster et al (2014)	Aphasiology	SLPs' perspectives on management of aphasia in acute hospital setting, and factors that influence practice	Social constructivist paradigm; interpretive phenomenology; single semi-structured in-depth interviews (66-111 mins); thematic analysis	Purposive maximum variation sampling: 14 SLPs from 36 respondents	Australia	Aphasia (acute hospital)
Hallé et al (2014)	International Journal of Language & Communication Disorders (IJLCD)	Explore process of working with significant others of people with aphasia in rehab setting, from point of view of SLTs	Grounded theory; individual semi-structured interviews (60-135 mins)	8 SLTs via practical (rather than ideal) theoretical sampling	Canada	Aphasia (working with significant others)

Author(s)	Journal	Aim(s) / Research Question(s)	Design	Participants	Country	Topic
Hersh (2010)	Topics in Stroke Rehabilitation	To make explicit an aspect of practice that is generally implicit, difficult to explain, and only rarely aired in professional literature: ending relationships with clients	Narratives of stories that have 'stuck in the mind' or 'seemed significant'; drawn from semi-structured interviews (1-2 hrs); analysis influenced by grounded theory	Drawn from interviews with 30 SLPs	Australia	Ending therapeutic relationships (aphasia)
Hersh et al (2015)	Disability and Rehabilitation	To give space to the detail and rich experience captured in stories of an SLP working with Indigenous Australian clients with acquired communication disorders	Re-analysis of interview using narrative thematic analysis and structural analysis	Narrative re-analysis of interview with 1 SLP (from Hersh 2010)	Australia	Working with Indigenous Australians with acquired disorders
Hinckley (2005)	Aphasiology	To explore the emotional aspects of a shift in therapeutic ideology and clinician role as perceived in one representative therapy session	Autoethnography; reflection on one historical session; discussed in contemporary phone calls with client	1 SLP	USA	Shifting therapeutic paradigm (aphasia)
Iacono and Cameron (2009)	Augmentative and Alternative Communication	How SLPs perceive their role, best practice, facilitating / hindering factors in relation to AAC in early language intervention	Qualitative design; group interview (6), teleconference group (5), individual phone interview (2), face-to-face interview (1); theoretical thematic analysis	14 SLPs	Australia	AAC in early language intervention
Kenny et al (2010)	American Journal of Speech-Language Pathology	Approaches to ethical reasoning and resolution demonstrated by experienced SLPs	Narrative approach based on case examples or stories of specific events; analysis at individual (narrative) and group (thematic) levels	10 SLPs	Australia	Responses to ethical dilemmas

Author(s)	Journal	Aim(s) / Research Question(s)	Design	Participants	Country	Topic
McCartney et al (2005)	IJLCD	SLT opinions on working as participant researchers through paired assistants in a specific case study context	Case study with participant researchers who helped develop the 27 interview questions; content analysis	5 SLTs (participant researchers)	Scotland	Working through assistants
Ritzman et al (2006)	Communication Disorders Quarterly	How a school-based SLP implemented an inclusive, collaborative, classroom-based service delivery model	Qualitative case study (case, description, themes, assertions); 3 in-depth interviews and 7 observations	Purposeful sampling of 1 SLP (instrumental case)	USA	Inclusive classroom-based service delivery
Warden et al (2008)	The South African Journal of Communication Disorders	Explore the essence / lived experience of being a speech and language therapist in the context of a rapidly changing service	Individual in-depth phenomenological interviews, 1 initial question (90 mins) + follow-up (30 mins), phenomenological analysis	Purposive sampling, 7 SLTs	South Africa	Being a speech and language therapist
McCurtin and Carter (2015)	Journal of Evaluation in Clinical Practice	Examine what actually constitutes the reasoning provided by SLTs for treatment choices and whether science plays a part in those decisions	Phase 2 (qualitative component) of a mixed-methods study; focus groups; thematic analysis	3 focus groups, 48 SLTs	Republic of Ireland	Complexities and paradoxes of clinical practice
Page and Howell (2015)	Journal of Interactional Research in Communication Disorders	Develop a theory to describe how SLPs who work with people with aphasia understand current assessment and intervention and how it changes over time	Exploratory qualitative, systematic grounded theory design; theoretical sampling; individual semi-structured interviews (45-90 mins) 6 open-ended questions	'Maximum variation purposive sampling' 10 SLPs (data saturation)	USA	Aphasia
Foster et al (2015)	IJLCD	Understand SLPs' conceptualisation and implementation of evidence-based practice for acute post-stroke aphasia	Response to emergent theme in data during Foster et al. (2014) interviews; interpretive phenomenology; semi-structured in-depth interviews	Purposive maximum variation sampling: 14 SLPs from 36 respondents	Australia	Aphasia

3.4 Applying the idea of interpretations of interpretations

Blending realist sampling with meta-ethnography went some way towards meeting the three aims of the qualitative synthesis (3.1). For example, it added confidence and rigour to decision-making around methods for the primary study, and drew attention to the high proportion of papers related to the aphasia jurisdiction. However, as anticipated at the end of 3.2, the dilemma I now faced was whether to attempt any more with the final sample of 16 papers and, if so, what and how.

After the realist sampling, while embarking on the primary study, I experimented with routes to advance the meta-ethnography *as a discrete empirical study*. In that respect, the work invested was not successful. One reason may be the distance between my aims and those of the included reports. As research synthesis methodologist Harsh Suri observes:

> Different degrees of interpretation are required according to the conceptual distance between the primary research study and the purpose of the synthesis. The higher this conceptual distance is, the higher the level of abstraction (in the sense of distillation) and interpretation will be. For example, high degrees of interpretation, bordering on transformation, are required in a synthesis that addresses a question different from the focus of the included primary research studies (Suri 2014, p.116)

A second reason is the critical realist underpinning of the synthesis, reinforced by the realist sampling approach. Reflective notes confirm provisional efforts to advance the synthesis opened up my thinking, enabled me to make connections between different data, and fed into interviews, focus groups and the developing practical social theory. The sample therefore made sense not within itself (the data), but as an ongoing contributor to the interplay between theory and empirical work (2.2.4) about practice change.

Although this presents problems for communicating the contribution of the qualitative synthesis as 'a meta-ethnography', a synthesis involves reduction, abstraction, and relational thinking, and "meta-ethnography is but one more interpretation" (Noblit and Hare 1988, p.25). In line with a case-based sociological inquiry, a useful heuristic in constructing a meta-ethnography is "one case is like another, except that…" (Noblit and Hare 1988, p.38). While

abduction (2.2.4.2) is the core strategy of meta-ethnography, retroduction (2.2.4.3) brings an additional critical realist dimension. The following section comprises examples of how I both tested ideas from the studies in different frames of interpretation (abduction) and asked what made it possible for findings to be so (retroduction), which helped me develop ideas around practice change dimensions, clusters and platforms.

3.4.1 Dimensions of practice change

Drawing on Noblit and Hare's (1988) typology of relationships between study findings as reciprocal, refutational or line of argument, I made notes about comparing and contrasting possible dimensions of practice change, paying particular attention to what appeared contradictory or in tension (Table 3-4).

Table 3-4: Examples of ideas in tension

Physical change	⟷	Achieved mentally
Moving on	⟷	Holding on
Generalist	⟷	Specialist
Core	⟷	Luxury
Certainty	⟷	Uncertainty
What matters	⟷	What happens

Sometimes I focused on one paper if its ideas were particularly relevant to my primary study. For example, I was going to interview community generalist therapists. Cameron and Muskett (2014) explored what such therapists do when they recognise children may have autism spectrum disorder, but the paper was also relevant to understanding hierarchies within the profession and its jurisdictions (generalist-specialist continuum, Table 3-5). Confidence in this interpretation came from Warden et al. (2008), who interviewed the South African equivalent of community generalists, but also from the papers where interviewees were more specialist. Different data, such as the disproportionate number of papers on aphasia, provided further weight. In addition, jurisdictional

tensions introduced by autism spectrum disorder in paediatric services were even more exposed in Foster et al.'s (2014) exploration of the impact on aphasia practice from the expansion of speech and language therapy into the jurisdiction of dysphagia.

Table 3-5: Generalist-specialist continuum (Cameron and Muskett, 2014)

Data for translation	My ideas for reduction
"participants presented themselves as not being 'experts' in the field of ASD" so "not 'qualified' to diagnose" p.319 (9)	Generalist therapists may consider themselves inexpert in comparison with specialist therapists; one way this is distinguished is through being qualified (or not) to diagnose
"restrictions of working as a single discipline rather than in a multi-disciplinary team" p.323 (11)	Generalist therapist as professionally isolated
"lack of access to support from specialist services" p.323 (12)	Generalist therapist as unsupported by specialist services
"the pressures of seeing children in the context of large primary care caseloads" p.323 (13)	Generalist therapist as dealing with large, mixed caseload
'Being the bearer of bad news' (subtheme)	Generalist therapist as the person who has to initiate difficult conversations about the future
"individual professionals' perspectives on early identification are likely to be characterised by complexity and ambivalence, reflecting directly the complexity of the services and contexts in which they practice" p.324 (1)	Generalist therapists work in complex services and contexts Complexity and ambivalence are integral to a generalist therapist's work

3.4.2 Clusters of practice change

I also played around with clustering and categorising the ideas underpinning the studies, in the process constructing a provisional model (Figure 3-4) to scaffold further interpretation. The first cluster of studies (comparing actual practice with idealised practice) looked at what therapists reported doing and related this to a benchmark. The second (investigating how practice is shaped) looked at influences on practice.

The third cluster (changing to a different service model) involved a shift in the structural context of participants' work, enabling them to compare it with their usual practice. The fourth cluster (becoming a better therapist) emphasised therapists' agency. Hinckley's auto-ethnography (2005) bridged the third and fourth clusters, as it involved her changing service models mentally without the assistance of a structural shift. The fifth cluster (bringing therapeutic relationship to a close) was trickier to categorise, as it addressed a structural part of all practice which is bound up with ideas about human flourishing.

Both the first and second cluster - implicitly or explicitly - used the idea of evidence-based practice as a reference point, an insight into the contemporary cultural context of speech and language therapy practice. The process of clustering the studies also drew my attention to the potential of explanatory frameworks (2.3) to act as a scaffold or a cage depending on how critically they are deployed. By noticing and reflecting on communicative changes in interviewees, including body language, when 'evidence based practice' was raised, Foster et al. (2015) were able to understand its narrow interpretation and disempowering effect. Page and Howell (2015) were also investigating aphasia practice. Their respondents may not have felt the same way, but this remains unknown because evidence-based practice as an explanatory framework was assumed.

Figure 3-4: Model of how papers clustered as basis for further interpretation
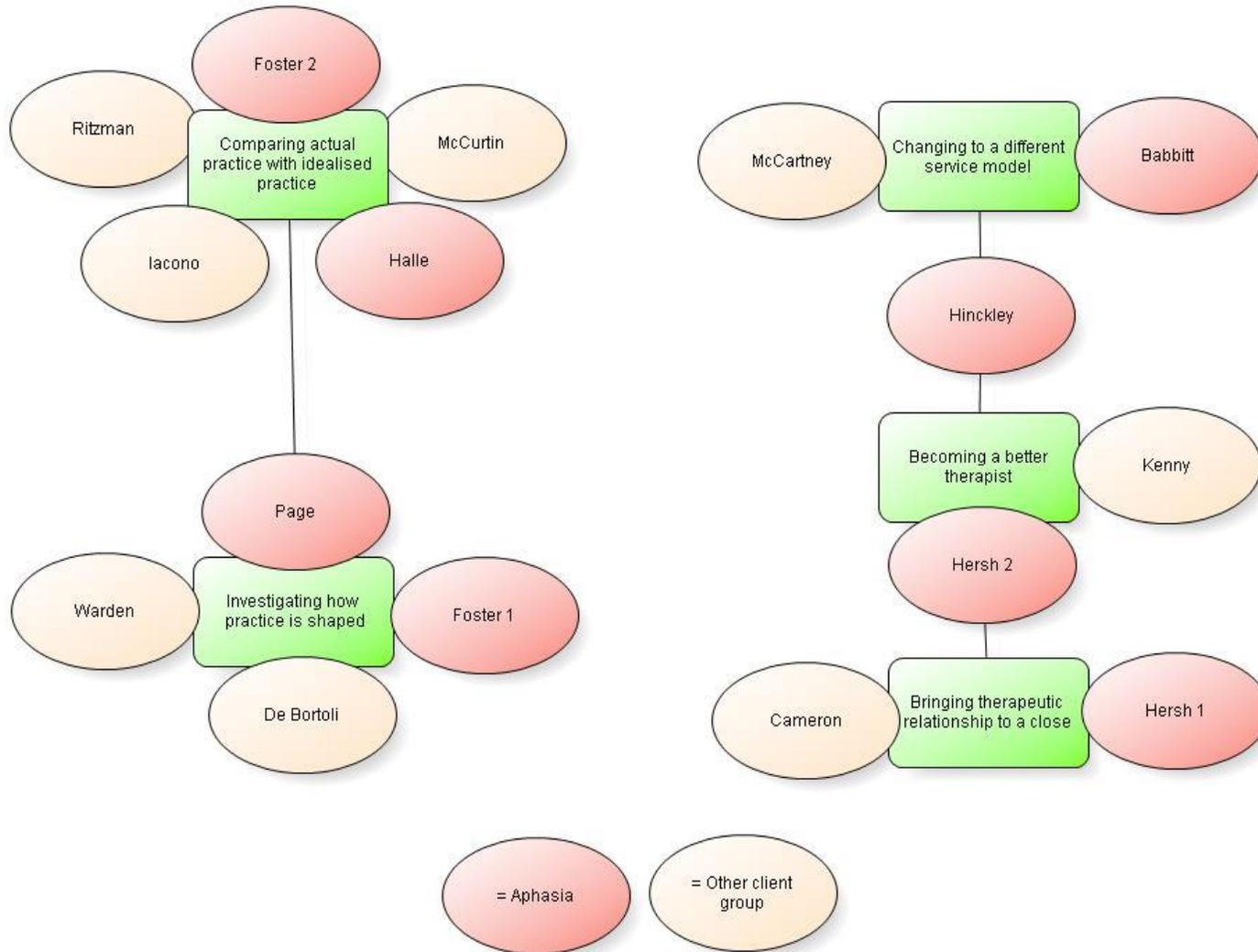
3.4.3 Platforms for practice change

Having structure-agency-culture relationships as an explanatory framework (2.3.2) helped me think what made findings of a study possible. For example, Ritzman et al. (2006) presented five themes to explain how a speech-language pathologist managed to deliver 'textbook' collaborative intervention, proposing 'advocacy' as the main theme. However, this therapist was based in only one school, and had a caseload of 35. In contrast, de Bortoli et al. (2014) discussed the "fragmentation" of therapists' work across different school settings and their perceived need for a "more substantial presence" (p.65). Number of settings and caseload size may therefore be among the necessary conditions making 'advocacy' possible, effective and sustainable.

Kemmis's Practice and Practice Architectures (1.2.2.1) helped me consider further the idea of new platforms opening up new possibilities while closing down others. To explore this fully, participants had to have experienced a contrast. McCartney et al.'s (2005) interviewees had applied to work on a research project where half of their therapy was delivered directly and half through speech and language therapy assistants. Their reflections made visible a deeply held attachment to direct work with clients held in place by a number of architectural strings. Babbitt et al.'s (2013) interviewees spent periods working in intensive comprehensive aphasia programs (ICAPs). Through this they learnt they could influence recovery more than they had previously realised, and that what they did made a meaningful difference to clients. Perhaps counterintuitively, more intensive therapy meant more - not less - time was spent on planning, report writing and thinking about the client (Table 3-6), but there was intrinsic reward from its effectiveness.

Table 3-6: Babbitt et al. (2013) on therapy time in intensive programs

"needed more time to write reports" p.403

"time spent thinking about and planning the therapies" p.403

"time spent…reading current research articles about evidence-based practices" p.403

"time spent…meeting with other clinicians and mentor staff to discuss patients and treatment approaches" p.403

"spent more time thinking about their patient or therapy tasks outside of the routine day" p.403

"thinking more about patients in their off time, including dreaming about their patients" p.403

Without the benefit of an actual structural change seen in McCartney et al. (2005) and Babbitt et al. (2013), Hinckley (2005) changed the architecture in her head to enable a move from traditional practice to a life participation approach. Her experience of embarking on something different from colleagues, particularly when they could potentially observe her, suggested that considerable cultural pressure contributes to the continuation of entrenched practices. In addition, the shift was made possible not only through Hinckley's individual determination and the persuasiveness of arguments for a life participation approach, but a pre-existing platform (intensive program, available piano, and a client with whom she shared a number of personal similarities and so could more safely adopt the necessary position of 'not knowing').

3.5 From synthesis to primary research

In this chapter I combined realist sampling with meta-ethnography for a qualitative synthesis component of a case-based sociological inquiry. This provided learning, context and theoretical sensitisation for my primary study and fed into the practical social theory (chapter 5) by developing ideas including dimensions, clusters and platforms of practice change (Table 3-7).

Table 3-7: How the qualitative synthesis helped generate the practical social theory

Clusters of ideas in sample	Particular influence on Practical Social Theory
Comparing actual practice with idealised practice	• Explanation (Caseload) • Model of intervention change (Theory; Logistics) • Explanation (Candidacy)
Investigating how practice is shaped	• Explanation (Caseload) • Explanation (Service)
Changing to a different service model	• Model of intervention change (Logistics) • Cases of practice change
Becoming a better therapist	• Cases of practice change
Bringing therapeutic relationship to a close	• Explanation (Candidacy)

To complete section I (What I Did), chapter 4 will explore the methods used in the primary study component of the research design.

4 Doing the primary research

4.1 Choosing fit-for-purpose methods

This final chapter in the 'What I Did' section is the methods for the primary study component of the case-based sociological inquiry. To be fit-for-purpose, these had to enable me to explore, from the perspective of community speech and language therapists, what SSD practice change was, how it had happened, and why there were different trajectories of change (chapter 1). They also had to be congruent with the principles of critical realism and the theoretical structure outlined in chapter 2, and take account of the learning from the qualitative synthesis (chapter 3).

The primary study's contribution to the practical social theory (2.3.4) was developed using the methods in the Figure 4-1 schema (p.116). This was an iterative rather than linear process. It largely fell into three stages, each carrying through to the next, with 'comparing' as a running thread. In this chapter, I will use this schema to explain the methods behind the findings reported in chapters 5-10.

4.1.1 Comparing

As a way of describing the world, or a route to understanding and explaining it, social science harnesses "that most distinctive of sociological techniques – the comparative method" (Byrne 2005). However, what researchers do with it differs. In this case-based sociological inquiry, I compared in order to deconstruct complexity, with "no assumption that all causes lie on the same analytical level" (Abbott 1992, p.68). This meant juxtaposing ideas and data across different analytical levels throughout the research to identify the best configurations and explanations of practice change. Rather than a separable activity, comparing is therefore a thread running through the methods.

Figure 4-1: Methods schema for primary study
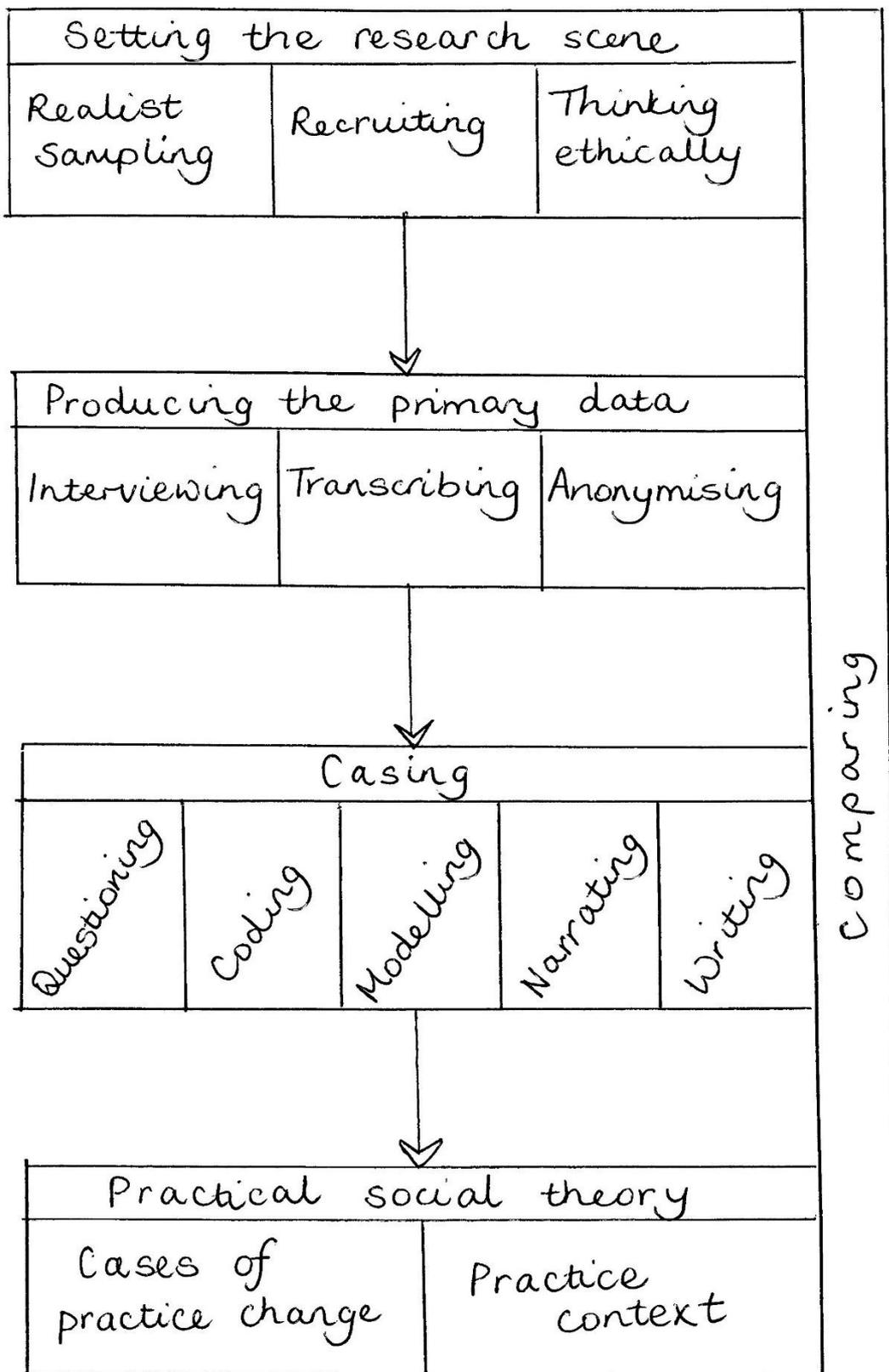
4.2 Setting the research scene

4.2.1 Realist sampling

Implementation of realist sampling in the qualitative synthesis (3.3.3) and the primary study developed from reading Emmel (2013). From purposive work to choose the initial sample (people in particular settings with a particular experience), through developing the sample of practice changes (by becoming more strategic about who to interview based on emerging connections and contrasts), the final sample was effectively the cases of practice change. As these were configured from but cut across participants and settings, I hoped research users would relate them to their own practice and context.

4.2.1.1 Step 1: Purposive work to choose initial sample

Choices about the initial sample were based on "fragile ideas" (Emmel 2013, p.6) about similarities and differences between potential participants that might be relevant to the study aims. The people best placed to help answer the research questions were speech and language therapists:

a) whose caseloads included children with SSD (minimum of 20% as a rough guide)

b) who managed[17] these therapists (and therefore shaped service delivery)

However, I wanted to understand not just experiences of practice change but how variation in experience and resultant outcomes were shaped by context. I knew services were taking different approaches, and that within services individuals may have experienced the same practice change. I had anecdotal evidence from England that therapists working privately had implemented and transferred practice changes to NHS work. Taking accessibility, geography and political context into account, I decided to sample therapists in Scotland from:

c) three NHS areas

d) private practice

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[17] In Scotland, speech and language therapists are by and large still managed by speech and language therapists

Finally, I wanted social aspects of practice change in context to emerge without assuming the make-up of causal groups (2.4), so:

e) potential participants would decide and organise themselves if they wanted to talk about practice change experiences individually, as a pair, or as a focus group.

Given the historical professional focus on autonomy and individual responsibility for a caseload, I anticipated most would choose an individual interview. This would also be the easiest option given the coordinated effort needed to organise a group. Moreover, the commitment to anonymity for participating services effectively limited group membership by service boundary. As a consequence, different patterns in how people opted to participate *could* be analytically significant.

Number of participants is not in itself relevant to the ultimate usefulness of research, and pre-specification risks under or over sampling. However, there are practical and ethical reasons to make estimates, such as letting departments know how much staff time may be involved. I set a maximum of 50, and advised each service to expect to have up to 12 therapists and up to three in a managerial role taking part in an interview or focus group. I allowed for up to five from private practice, as Scotland has a far smaller proportion than England.

I decided not to sample speech and language therapy assistants because they work under direction. However, one participant discussed how an assistant had observed differences in practice between therapists through the materials they requested. Others talked about the process and impact of including assistants (or not) in different kinds of approaches. Not accounting for the value of assistants' direct experience of working with a number of different therapists introduced a sampling limitation.

4.2.1.2 Step 2: Purposeful choices to develop sample

Purposeful choices from the volunteers were assisted by a non-statistical questionnaire. Devised to identify relevant similarities and differences, it covered job bands, whole time equivalent, location, caseload make-up, training, supervision of students, other careers, gender, and age band. Anecdotally,

return from maternity leave could make practice change more salient, so one question asked about recent periods away from work. How an individual scored a rating scale about how easy it would be to think of practice changes was interesting, but not usable for developing the sample.

At a service level, I selected three NHS services in Scotland where social aspects of practice change might be working differently. I understood through my networks that one had specifically targeted SSD intervention, another had supported clinical effectiveness projects, while another was using technology to explore social learning. As my contact with them grew, I continued to develop potentially relevant dimensions of difference (Table 4-1).

Table 4-1: Early differences between participating services

	NHS service 1	**NHS service 2**	**NHS service 3**
Approx. no. SLTs per geographical team	4-6	9-10	15-20
Skill mix	Within each team	Most therapists have diverse caseloads, not all restricted to children	High concentration of specialists in one team; have some specialist teams as well as geographical ones
Assessment	Joint assessment clinics within each team	Not known	Assessment clinics (not known if across the board)
Caseload	Collegiate responsibility	Individual responsibility	Individual responsibility
Strategic direction	Cross-service expectations combined with devolving responsibility for implementation to team level	Increased use of technology for intervention and learning across the service	Strong intention, and in process of working towards, the distinct teams offering the same service pathways

As recruitment (4.2.2) and data collection overlapped, I started with people as they volunteered, using the questionnaire data to ensure sufficient diversity so the quality of the sampling strategy would not be compromised. I gradually thought at a whole sample level who to interview, and at what point. A mental

image of sampling ladders helped me reflect on the most informative contrasts within and across participants (Figure 4-2). Having sufficient people who had moved up, down and across metaphorical ladders made it more possible to test the validity of the developing cases.

Figure 4-2: Sampling ladders
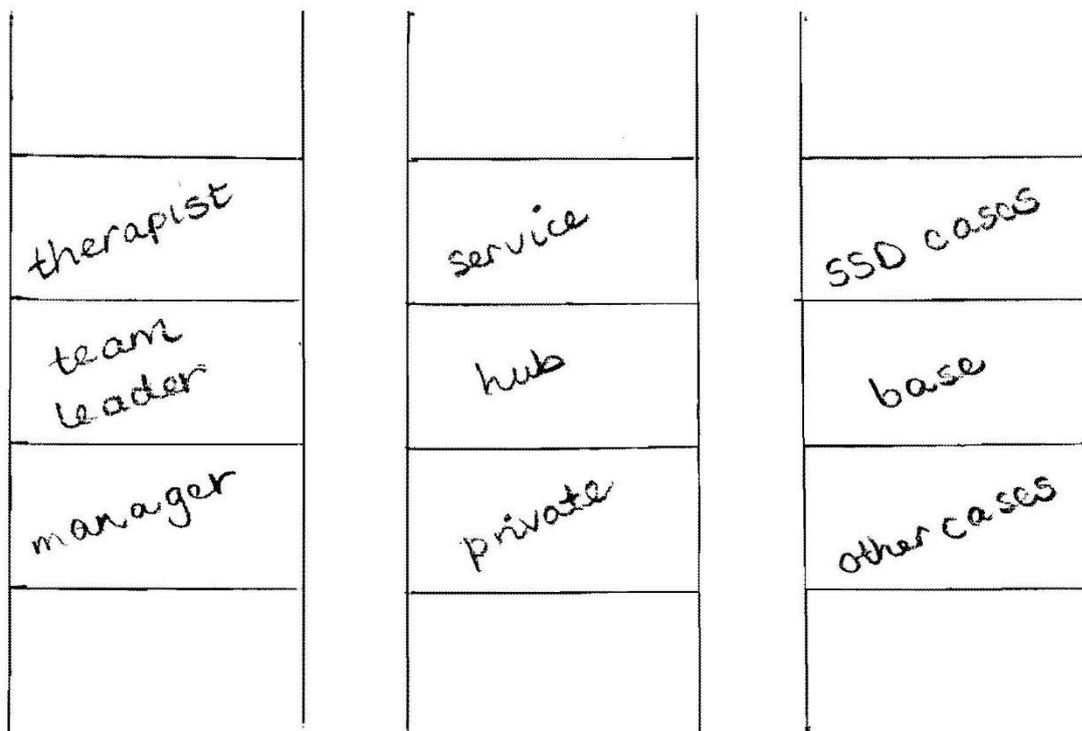
As services differed in staffing, study recruitment and practice change experiences, it was a mistake to set the same maximum number of participants for each. I therefore applied for ethical permission to change the distribution, which was granted by chair's action.

4.2.1.3 Step 3: Casing practice change

The configurational process which produced and explained different cases of practice change is explored in 4.4.

4.2.2 Recruiting participants

Recruitment depended on sustained effort to capture the imagination of potential participants, ensuring they:

1) understood what I was asking, why, and what I intended to do with the data

2) appreciated I was seeking diverse experiences of SSD practice change, including where therapists had few or no examples

3) were aware I was not imposing pre-conceived ideas about the what, how and why of practice change

4) had sufficient information and trust in me to decide whether or not to contribute their time and experience.

I did not know who would remember me from Speech & Language Therapy in Practice magazine or clinical practice, or how this would impact on my reception, but felt it was vital to meet as many potential participants as possible in person. As I was interested in social aspects and wanted to minimise the administrative and time burden on services, I hoped to be given slots at already scheduled meetings.

I approached a speech and language therapy manager in each service I wanted to involve. I was invited by two to a managers' meeting; the other service preferred discussion by email. Managers arranged for me to attend forthcoming staff meetings in two services, and in the other gave me team leaders' contact details so I could liaise directly. The 12 staff meetings stretched over six months, with all of one NHS service's meetings completed before any others took place. When a meeting proved difficult for one team, two members of staff who self-identified as potentially eligible agreed to view a recorded powerpoint presentation[18].

The staff meetings varied in size, formality and the extent to which I was included. In around 20 minutes, I introduced the study using a short powerpoint presentation (Appendix 1), answered questions, handed out Research Study Information, and requested email addresses for direct follow-up about participation after 24 hours. I acknowledged it could be difficult in that social context not to add their email address, but stressed it put them under no obligation. I provided extra information sheets for the few eligible therapists who were absent.

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[18] Available at: https://youtu.be/l9YDGWXcmAw

Approaching meetings with an ethnographic sensibility (1.3.3) helped inform subsequent interactions. My background made it easier to access managers and staff. However, although the welcome was always polite and friendly, differences in how I was received *as a researcher* (from warily to enthusiastically) were not predictable. Similarly, the number and types of questions and discussion varied; at one meeting confidentiality was a concern, while at another the study's sociological - rather than psychological - rationale was queried. Anticipating concerns helped; for example, being explicit that managers were happy for therapists to participate in work time seemed particularly reassuring. Some questions arose from unfamiliarity with research boundaries, such as an expectation I might feed findings into a service evaluation. Practically, I also had to be prepared for the unexpected, including technical problems presenting the powerpoint.

In the initial email to each member of staff who had given permission for direct contact I thanked them, attached an electronic copy of the Research Study Information, and invited further questions. I asked for their preferred postal address if they thought they would like to take part, so I could send further information comprising the consent form, a sheet to use if they would prefer a paired interview or focus group, and the brief questionnaire.

I monitored the nature and dates of contact using an Excel spreadsheet, and used a Word table to record progress and arrangements with consented individuals. To assist sampling choices, I transferred questionnaire responses to an Excel spreadsheet using volunteers' study identification code rather than their name.

Most exchanges were straightforward. I had to advise one respondent, whilst maintaining confidentiality, that names provided for a focus group did not tally with colleagues' responses. After some discussion, recently qualified therapists concluded they had insufficient experience of practice change. I followed up non or partial responses once; replies suggested they had forgotten or not got round to it. On rare occasions I made additional efforts such as a phone call or letter. Where this included someone with a senior or gatekeeping role, it was important to acknowledge and put aside feelings that they 'ought' to take part.

For NHS services, I used an Excel spreadsheet to monitor the success of the recruitment strategy by recording meeting dates, response patterns and attrition (with reasons where applicable) by service pseudonym. I then identified potential private practice participants via the Association of Speech & Language Therapists in Independent Practice public website. I emailed those listed as having expertise in 'articulation and phonology' the Study Recruitment Information and a link to a five minute recorded powerpoint presentation. The Chair of ASLTIP Scotland also circulated an email on my behalf to members. Thereafter the consent process was the same as for NHS participants.

4.2.3 Thinking ethically

4.2.3.1 Integrity and reflexivity

Every aspect of research is infused with ethical uncertainties. I approached it with reflexivity and an ethic of care, as:

> Ethics is about *how* to deal with conflict, disagreement and ambivalence rather than attempting to eliminate it (Edwards and Mauthner 2012 p.25)

Practically, this meant recognising my responsibilities, giving priority to relationships, and responding to contextual detail.

I was sensitive to pressures on services, but hoped participation could be rewarding and enlightening. I recognised passion for making a difference might be tied to preferred approaches, and opening up practice could trigger emotions including defensiveness, shame or guilt. I wanted to harness social mechanisms, whilst ensuring individuals understood their right to consent or decline and the limits of anonymity in small, connected communities (Damianakis and Woodford 2012).

Memos (Figure 4-3) helped me reflect on how aspects of myself or my actions might affect relationships with and between people and groups (colleagues; therapists / managers; participating services; services / profession; NHS / private practitioners), and how this might impact on the data collected and how I chose to analyse and present it.

Figure 4-3: Early reflective memo excerpt

Memo

At times it may be an advantage that I am a speech and language therapist. At others it may introduce power imbalances, for example if I am well known to one participant in a group.

It will be particularly challenging if I am disappointed in or concerned about reported practice, as I am protective of the profession as well as clients.

As participants were unlikely to have experience of qualitative research, the onus was on me to anticipate, recognise and respond to ethical challenges. In addition to valuing participants in themselves, the study had to make a wider contribution to knowledge around practice change. Risks included lack of diversity, especially if the only participants were the most proactive staff who were positive about the role of research. An overly challenging level of reflection risked superficial data, while contributions framed by what participants thought I expected of a 'good' therapist risked predictable data.

I took steps to address ideals and risks. I originally intended to ask about unsustained or unattempted practice change. As this provoked anxiety about how managers might receive responses, I decided to ask about practice changes that had actually happened; other scenarios might arise naturally.

The Research Study Information offered comprehensive explanation of what I was expecting and why, and was improved following minor recommendations from four speech and language therapists. It removed expectations that practice changes should be based on research, and encouraged everyone to feel they had something to contribute. Participants could choose the practice changes, number of people (individual, paired, focus group), time (in or out of office hours), mode (face-to-face, telephone, email), and place (work, home, other venue). If desired, this allowed complete privacy from colleagues. While this participant-centred approach demanded more flexibility on my part, there was no theoretical reason for standardisation; moreover, patterns of preferences might be relevant to the analysis.

At staff meetings, I was open about anonymity challenges, but made clear I would not reveal services or individuals. I presented the research as an opportunity for the profession in Scotland. To reduce pressure to 'perform', I

emphasised collaborative idea generation (Alvesson 2011) with no right or wrong answers. I framed participation as a contribution reflecting what was in their mind at the time rather than a fixed truth, which I would weave into cases that would be useful to the profession. I reinforced this in two subtle ways. Firstly, I did not offer to send transcripts (although was prepared to do so if asked). Secondly, I explained anonymised transcripts would be archived for future use by bona fide researchers.

I emphasised study quality depended on a large pool of volunteers from which I could select strategically. However, on implementing this, I felt embarrassed. Those not chosen had gone to the trouble of consenting, seemed keen, and their perspectives might have made a difference to my conclusions. I reminded myself of the realist sampling rationale (Figure 4-4), kept the volunteers up-to-date, and decided not to 'push' recruitment of additional potential volunteers (such as team leaders who did not see children with SSD).

Figure 4-4: Sampling memo

Memo 26/6/15

I have been feeling under pressure to book in lots of interviews as I am running out of time. However, what would be the purpose of this, other than to get 'data collection' out of the way? It means any idea of purposeful choices as the study progresses are out of the window, as is analysis as I go along. I do not want to be in a position where I have missed out on or wasted interview opportunities due to too little attention to choices shaped by the analysis.

4.2.3.2 Formal processes

Stirling University's School of Health Sciences Ethics Committee approved the study on 19th November 2014 (Appendix 2). Chair's Action approved redistribution of sampling across sites on 25th August 2015 and the email introducing the study to members of the Association of Speech and Language Therapists in Independent Practice on 4th August 2015. Forms (Research Study Information (Therapists[19]), Focus Group Request, Consent (Therapists), Questionnaire and Topic Guide) are in Appendices 3-7.

It was unclear whether I needed to go through the Integrated Research Application System. Having completed the process, the NHS Ethics Central

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[19] Forms for managers differed only slightly, and are available on request.

Booking System advised on 15th January 2015 the study did not qualify as it only involved NHS staff. R&D Management Approval was received from the three participating services on 30th January, 19th March and 31st March 2015, with Letters of Access.

4.2.3.3 Data management

Electronic data was held on a secure, password-protected university computer, with paper data kept securely. File labelling did not compromise confidentiality, and I gave attention to version control. Digital voice recordings were transferred to the computer as soon as practical, and the recording deleted from the portable device.

Digital recordings would be destroyed at the end of the study, with anonymised transcripts and study data offered to a secure data archive (Corti et al. 2014).

4.2.4 Describing the participants

Realist sampling (4.2.1), recruitment (4.2.2) and ethical thinking (4.2.3) resulted in a pool of 56 therapists. Characteristics of the 56 who consented are presented as aggregated data to protect their anonymity whilst demonstrating the sample's diversity and relevance. As speech and language therapy is a small connected community, and more so in Scotland, anonymity is further protected by presenting all as female, with no information about ethnicity. Readers should assume this was discussed with any participants who may have felt marginalised or misrepresented, and that the actual profile of participants was in line with the national picture (NES 2013).

To minimise pressure on potential participants and administrative burden on departments, I did not seek hard data on staff numbers. Combining available data with informal observation, I estimated 88 NHS speech and language therapists could have been eligible, including those not present at meetings, of whom 81 gave permission for direct contact. Of these, eight did not respond, four said they were ineligible, four declined for personal reasons, two felt they were too newly qualified, and five cited capacity issues at work. A further six did not return consent forms, leaving 52 potential NHS participants. I estimated 21 private practitioners across Scotland could have volunteered; 12 did not

respond, four said they were ineligible, and one declined without a reason, leaving four potential private practice participants.

Fourteen of the 56 volunteers were not interviewed; I tried to arrange interviews with two of them, but they did not respond. The characteristics of the 14 are in italics in square brackets. Overall distribution reflects the balance of purposeful choices, and judgements over sampling priorities (e.g. characteristics of people who chose to participate as a focus group). Checking consent versus participation per category suggested a limitation may be the proportionately lower insights from people who qualified 1991-2000.

Services are anonymised as [Blaeshire], [Staneshire] and [Clootshire] (4.3.3). At interview, 19*[8]* participants were based in [Blaeshire], 11*[5]* in [Staneshire] and 9*[0]* in [Clootshire], with 3*[1]* taking part as private practitioners. Most (29)*[10]* worked full-time (0.8-1.0 whole-time equivalent (WTE)), with 11*[3]* part-time (0.5-0.75 WTE) and 2*[1]* very part-time (less than 0.5 WTE). Of the 39*[13]* NHS participants, 20*[8]* were NHS band 5 or 6, 13*[4]* were NHS band 7 (including 5*[2]* team leaders), and 6*[1]* were NHS band 8.

Thirty*[11]* had an undergraduate speech and language therapy qualification, 8*[3]* qualified as postgraduates, and 4*[0]* had gone on to do a Masters. Most (31*[13]*) qualified in Scotland, 9*[1]* in England, and 2*[0]* elsewhere, with 6*[1]* qualifying by 1980, 9*[1]* from 1981-1990, 4*[7]* from 1991-2000, 17*[4]* from 2001-2010 and 6*[1]* since 2011. At interview, 6*[1]* participants were in their 20s, 15*[4]* in their 30s, 6*[3]* in their 40s, and 15*[5]* were aged over 50, with *[1]* unknown. For 25*[10]* participants, this had been their only career, and 3*[0]* participants had returned to the profession after a lengthy break.

Of the 40*[13]* participants with a clinical caseload, almost all worked as community paediatric generalists, with some having other and / or additional roles (e.g. caseload type / specialist / leadership). While 23*[10]* took a student every year, and 7*[0]* averaged more than one student a year, 10*[4]* did not generally take students. On estimating children with SSD as a percentage of their caseload, around half (21*[5]*) gave a figure between 40 and 60%, with the range from less than 20% (2*[1]*), to 80-100% (4*[0]*).

While 17*[8]* of the 42 participants had not received any SSD related training in the past few years, 6*[1]* had attended at least one Caroline Bowen two-day course, a further 10*[3]* had received internal training based on this, 5*[1]* were at Jan Broomfield's presentation at an SLI SIG[20] and 4*[1]* mentioned other courses they had found relevant.

The recruitment process was an opportunity to think about possible patterns of difference between services. There was higher non-response to initial emails from [Staneshire], higher non-returns of consent forms from [Clootshire] and [Staneshire], and higher active declines with reasons (personal and workload capacity) from staff in [Blaeshire]. This could have indicated [Blaeshire] staff felt more confident giving reasons for decisions, and / or staff in [Staneshire] felt less connected to the research aims.

It was clear from emails, post-it notes on consent forms and conversations that most [Staneshire] therapists had discussed their participation, and a few had tried to establish whether a colleague wanted to join them. Ultimately, however, all [Staneshire] volunteers presented as individuals. This differs starkly from [Blaeshire], where around half the volunteers were as pairs or focus groups, with others indicating they had weighed up the options as a team before deciding on individual interviews. This could have indicated staff in [Blaeshire] were more accustomed to making practice decisions as teams. To illustrate the point but preserve anonymity, Figure 4-5 is based on indications before recruitment and consent was complete.

Figure 4-5: Early participation response pattern

[Blaeshire]   [Clootshire]   [Staneshire]

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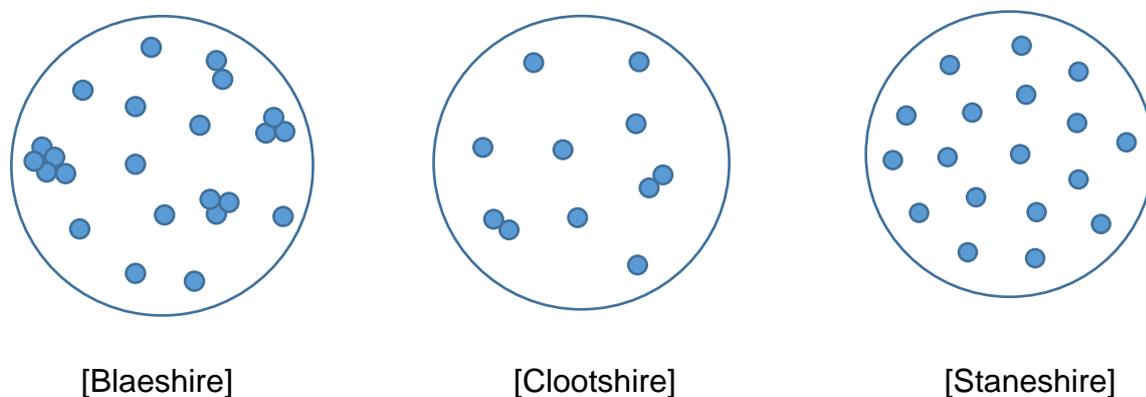
[20] Scottish Specific Language Impairment Special Interest Group, as it was then called

4.3 Producing the primary data

Making choices around sampling, recruitment and ethics explicit allows you to understand the context in which the study data was generated. Such transparency is crucial for judging how and in what circumstances the research is valid (4.5). The data itself was produced in three ways, all with an ethnographic sensibility: participant-centred interviews and focus groups, transformation of audio to written form, and anonymisation.

4.3.1 Interviewing

For this study, I needed qualitative, first-person data gathered in a limited number of natural settings. The research question referred to historical or ongoing experiences which were not formally recorded, and may have been undertaken individually or collectively. I therefore planned to gather the data through interviews and self-organised pairs or focus groups (4.2.1.1). The qualitative synthesis (3.3.4) supported keeping an open mind about what participants might define as practice change, encouraging them to use illustrative examples, and making it acceptable for them to discuss the emotional work.

Forty two participants were involved in 33 encounters (28 individual interviews; two paired interviews; three focus groups). One was by telephone, four at participants' homes, two in a health research facility and the remainder (26) in clinics or hospitals booked by the participants. Recorded time ranged from 48 to 112 minutes, and averaged 78 minutes.

4.3.1.1 Influences and choices

Interviewing and working with groups is not unique to researchers. I brought years of transferable experience as a therapist (following people's lead and exploring their solutions), campaigner and journalist. As a participant in qualitative studies, I had noticed how different actions of researchers, aspects of settings, and other participants impacted on how I felt, as well as how discussion unfolded. From my experience, the idea of standardised formats jarred.

Communication is dynamic, situational and contingent. I anticipated some participants would prepare and make notes, while others would go with the flow. I expected some to be thoughtful, others talkative. There might be humour, performance, metaphors, anecdotes, reticence and a range of emotions, even within one encounter. I wanted to retain my therapist's awareness of communication as multi-layered, convey my campaigner's passion, and use my journalist's nose for stories, while resisting urges to reach quick conclusions, persuade, or look for soundbites. Although there was no intention to empower, participants were gifting time and expertise; if possible I wanted them to get something from it. While Pawson (on 'realist interviews') reminded me to take responsibility for explaining all aspects of the research, I profoundly disagreed with his assertion:

> interviews cannot and need not handle values, beliefs or, still less, 'emotions' which must be left to whatever method the phenomenologists/feminists can best devise (1989, p.321)

Flick's (2000) 'episodic interviews' gave a vocabulary for what I was trying to do – harness human capacity for mental time-travel to recall experience of relevant events in context. Summarising question types and criteria of a successful interviewer helped me prepare and reflect (e.g. Kvale and Brinkmann (2009)), while Finch and Lewis (2003) informed practicalities of conducting focus groups.

Oral history literature drew my attention to relationships between individual and collective memory of the past from the perspective of the present (Bartie and McIvor 2013). The umbrella of critical realism enabled thinking about relationships between events and experiences, as well as structure and agency (Smith and Elger 2014, p.129), and sensitising theories (2.4.2) were a resource for thinking and questioning in the moment. From Rapley (2012) and Oakley (2016), I took further confidence to avoid dichotomies around formality, philosophy and structure because:

> I cannot know, a priori, what specific interactional dynamics are going to emerge. I cannot know a priori what specific trajectory of questions is going to help the participant explore, with me, the issues that the research is centered [sic] on. Such things are emergent; they are a product of the here-and-now interaction. (Rapley 2012, p.549)

4.3.1.2 A participant-centred approach

Being organised, prepared and respectful is a minimum professional standard. A participant-centred approach meant also being open to adapting my actions and communication depending on the participant(s) and situation. For example, questions in the Research Study Information and topic guide related to the work of practice change and were part of providing clear information about the study purpose. They were not intended for actual use, but as a platform for customised interaction that would enable connections and contrasts to emerge.

In practice this depended on awareness of the range of possibilities: attentive listening; facial expression, gesture or noises; modelling acceptable ways of talking (showing uncertainty, admitting vulnerability, questioning and revising thought process); choosing particular words; disclosing an experience or feeling; probing; holding a pause; debating or offering alternative possibilities; challenging; reassuring; or empathising. The interviews and focus groups involved multiple simultaneous judgements from a variety of vantage points, to the extent I saw myself both from me and as a fly on the wall. An ethnographic sensibility attuned me to place, access, smell, light, sound and interruption as well as interactional dynamics.

The types and extent of SSD practice change varied considerably, so the different emphases offered by a hybrid implementation-practice-profession lens (1.2) was a resource. For example, the importance of harnessing the Normalisation Process Theory component of Differentiation was apparent early on, unpacking the detail of usual practice was valuable when participants had fewer examples of change to discuss, and strong emotion was sometimes a sign to probe around jurisdictional tensions.

4.3.1.3 Consequences and limitations

This approach meant trusting participants. Occasionally I had to wait to discover the relevance of a particular path, only once feeling I had to steer discussion back to the research goal. Some participants commented on the luxury of time to talk about their practice with an interested listener, and their intention to act on insights that had occurred. On one occasion I was disappointed in my handling of consecutive interviews. It was useful to

recognise how a range of factors had affected my mood, so I could react differently if they occurred again.

My status and its impact was hard to evaluate. I had dreaded perceiving any participant as uncaring or lazy, so was relieved this did not happen. Knowing me personally or through Speech & Language Therapy in Practice had helped some people decide to participate, but may have put others off, while many had no prior knowledge of me. Sharing a profession (Chew-Graham et al. 2002) reduced social distance and seemed to encourage frankness and detail, but also meant I had to judge when to ask for clarification of terms or probe assumptions. I deliberately used my time out of clinical practice to reduce power inequalities and encourage detailed explanation.

Perhaps surprisingly, I had not anticipated being asked for advice, and felt I handled it clumsily on the rare occasions it happened. I hope to address this when I discuss findings with participants. It may have been a consequence of identity confusion (was I a therapist or researcher?), and lack of attention to identity work may be a limitation of the analysis (Checkland et al. 2007).

4.3.2 Transcribing

Transcription transforms one form of data into another so it can be more readily analysed, shared, or re-used. When generating qualitative data through interviews or focus groups, usual practice is to audio record the oral encounter then transcribe it as written text. This necessarily selective process involves multiple interpretive, ethical and practical judgements about whether, how and why to represent what has taken place. Transcription is therefore not only a set of technical procedures but an important methodological step.

In spite of helpful guidance in Rapley (2007) and Poland (2001), I faced practical uncertainty around how best to transcribe audio data for this study (Figure 4-6).

Figure 4-6: Transcription memo

Memo 21/7/15

I have just transcribed a part where there was a gulp and initially I wondered whether to transcribe it or not – having done so I realised it was a prelude to a particularly emotive section. This was backed up by the kind of passionate support it roused from the other participants, a real sense of their motives and actions being misunderstood, and of injustice that they had to defend their decisions to quite such a degree (possibly more strongly felt because it was from colleagues??) Non-verbal or paralinguistic features orientate me to what might be going on beyond the interview, more than words alone. Yet a transcript which has words turned into sentences, tidied up for written consumption, may risk losing this element where people express so clearly what matters to them.

Oliver et al. (2005) examined transcription methods-in-use to help decide how to address unanticipated challenges of representation and confidentiality in a sensitive public health project, and "soon came to see transcription as a diverse practice with often competing objectives" (2005, p.1274). Davidson's (2009) review of transcription literature from 1979-2009 covered the many ways transcription was defined and understood, how this had shifted over time, and how transcription was conducted and reported across different disciplines. Davidson concluded that empirical studies from a variety of disciplinary perspectives would increase understanding of how transcription can be approached, and why diversity is methodologically important.

I therefore carried out an empirical study using published papers identified through a highly specific systematic literature search to answer the research question: *How is the transcription process reported in realist-orientated qualitative studies in which data was generated via interviews and / or focus groups?* From the final sample (32 papers), I extracted transcription-related data and inductively derived a detailed descriptive coding framework, coding each paper as present or absent. I then tested all codes and supporting extracts against ideas about what was made visible through that reporting choice, by repeatedly asking 'What kind of visibility is this a case of?' Table 4-2 shows visibility types in order of frequency from top to bottom.

Transcription was most visible as a record of an encounter and as producing the data used for analysis. Detail on anonymisation went no further than stating de-identification took place. These aspects of visibility all represented

transcription as a technical process. Although transcription is open to interpretation and judgement, and can be repetitive and tiring, few reports indicated it was the result of human effort. Finally, only three reports hinted that extra insight was gained from listening to audio as well as reading transcripts at different points in the research process.

Table 4-2:Types of transcription visibility

Code	Type of visibility
None Verbatim Translate Accuracy Member check	Visibility of transcription as a record of an encounter
Storage Analysis Check Extract	Visibility of transcripts as primary data
Anonym	Visibility of anonymisation
Person	Visibility of the transcriber
Insight Listening	Visibility of transcription as audio to written form

As a consequence of this sub-study, and in the context of a critical realist approach and ethic of care, I made transcription as a methodological step more visible. In particular, I paid attention to how I was using (and attempting to transcribe) aspects of spoken language beyond words to clue me in to what was being communicated. I also explored how anonymisation at the point of transcription might be analytically helpful in forcing deep thinking from an early stage about how relevant aspects of context could be accounted for without compromising anonymity.

On a practical level, I committed to transcribing words and attributing speakers accurately, maintaining flow, and drawing attention to subtle cues about a speaker's or group's communication through impressions of emphasis, hesitation and humour. An unanticipated consequence was difficulty searching

electronically for phrases or words if they contained notation such as dots or dashes. The transcription key (Figure 4-7) is a hybrid of relatively standard and customised notation.

Figure 4-7: Transcription key

Words spoken, speaker and word order detailed as accurately as possible.

Orthography rather than phonetic symbols used (not about the specifics; archiving for non-specialists).

Within context of each interviewee's communication style, impressionistic notation is not generalisable across interviews: eg length of pause, emphasis, tone, laughter.

Encouraging noises not attributed when in pairs and groups unless very clear (happening at group level, and risks attribution error).

[ ] indicates anonymisation

[[ ]] indicates 'filler' words aimed at encouraging rather than interrupting the flow

(( )) indicates note by Avril, e.g. description of interruption that interferes with flow of interview, or non-transcribed section

( ) used for speaker (laughs) / (laughing), general (laughter) and other apparently communicative non-speech utterances such as (gulp)

: indicates prolonged sound

xxxx indicates unintelligible

{ } indicates best guess (poor intelligibility)

CAPITALS indicate emphasis (started on syllable, but too time-consuming for any benefit)

-   indicates started but didn't finish a word
< > used for speech sounds or target words

hhh indicates audible sigh out

.hhh indicates audible in breath

Impression of pauses indicated by .., …, (pause), (long pause), (very long pause)

Some use of punctuation (full stop, comma, exclamation mark)

4.3.3 Anonymising

Given the nature of small, connected communities (Damianakis and Woodford 2012), it was likely therapists within a service would know who had participated, and some across Scotland would know which services were involved. Geographical differences and variety of organisational models also meant participating services could be recognised by users of the research with local knowledge. I had to be aware constantly of the challenge of balancing the need for anonymity with the overall integrity of the study, where necessary discussing this with participants (Saunders et al. 2015).

In practice, my commitment to confidentiality was continually tested. If I met participants at an event, I had to be vague about how I knew them. When an interviewee said a colleague's name, my response could inadvertently communicate whether or not they were involved. Anonymisation brought its own challenges as I had to remember participants' real names as well as their pseudonym and use whichever was appropriate. Knowing I would be archiving data also influenced decisions. I marked two transcripts as containing particularly sensitive information about cases, and noted but did not transcribe short, highly personal reflective segments in another.

Using an Excel spreadsheet, I created an ID log capturing all anonymisation decisions. Sheet 1 was recruits and their pseudonyms; sheet 2 gave pseudonyms and brief context to non-participants mentioned in interviews; sheet 3 covered pseudonyms for services, divisions, hubs and place names; sheet 4 matched audio files to pseudonyms; sheet 5 was acronyms; and sheet 6 was general measures to disguise identifying data without losing its potential significance.

For general disguise, I banded certain data (years since qualified; length of career break; year of qualification; age; SSD as percentage of caseload). Other data was coded or categorised, including job band (standard band 5/6, advanced=band 7, senior leadership=band 8), whole time equivalent (full-time=0.8+, part-time=0.5-0.7, very part-time=<0.5); caseload (child, mixed, none); SSD training (e.g. SLI SIG, Caroline Bowen, internal, none); students per year (e.g. 0, 1); university attended (coded by number and Scotland / north

England / south England / overseas); type of qualification (e.g. undergraduate, postgraduate, masters); other qualifications (broad categories e.g. leadership, creative arts). I used the Scottish Government Urban/Rural Classification 2013-14 (6-fold) to describe areas and populations from Large Urban to Remote Rural. The Excel spreadsheet populated with these anonymised demographics is suitable for archiving with the anonymised transcripts.

I chose largely female-identifiable participant pseudonyms with a Scottish weighting, and occasionally changed these if potential compromises to anonymity became apparent. One original pseudonym (Caroline) was changed to Carolyn when I realised the potential confusion with Caroline Bowen. To protect confidentiality of participants as a whole, I did not give individuals the option to choose their own pseudonym.

Service pseudonyms ([Blaeshire], [Clootshire], [Staneshire]) incorporated Scottish words, without suggesting identifying regional characteristics. Services which were not part of the study were given letter codes. Developing the anonymisation codes for settings (Figure 4-8) was an essential part of identifying similarities in service structures, which were less obvious than their differences. Private practice is so small in Scotland that no information is shared about those participants' locations.

Figure 4-8: Anonymising services

Each service was coded at 3 geographical levels: area, division and hub:

- Area pseudonym: [Blaeshire], [Clootshire], [Staneshire]
- Division: A, B, C
- Hub: 1, 2 etc.

So [BA1] = Blaeshire division A, hub 1; [SC3] = Staneshire division C, hub 3

The combination of individual and service data risks both becoming more identifiable, particularly when individuals have crossed boundaries (Figure 4-2) so are contributing more than one perspective. For this reason, findings chapters 6 (Intervention) and 7 (Candidacy) have individual pseudonyms (Table 4-3), but chapters 8 (Caseload) and 9 (Service) have service-associated codes

followed by a number (Table 4-4). Each participant therefore has one pseudonym and at least one service code. Other people referred to by participants are given pseudonyms if they are within the service, or if identifying them would threaten anonymity. As some real names are also used, all pseudonyms are in square brackets throughout.

Table 4-3: Pseudonyms

[Aileen]	[Emily]	[Iona]	[Kate]	[Myra]	[Rowan]
[Audrey]	[Erin]	[Isla]	[Lorna]	[Natalie]	[Sally]
[Beverly]	[Fran]	[Isobel]	[Louise]	[Niamh]	[Shona]
[Carolyn]	[Grace]	[Jackie]	[Maureen]	[Nicole]	[Sonia]
[Diane]	[Hannah]	[Jayne]	[Megan]	[Pam]	[Sophie]
[Elaine]	[Hazel]	[Jenna]	[Melanie]	[Paula]	[Vivienne]
[Elizabeth]	[Heather]	[Jess]	[Morven]	[Rhona]	[Wendy]

Table 4-4: Service anonymisation

Service context	Code letter
[Blaeshire]	B
[Clootshire] (A or B)	C
[Staneshire]	S
Private practice	P

The passage of time boosted anonymity, as services moved on in their structure and practice, and some individuals left or changed roles, but this did not reduce the ongoing work of anonymising the data, or its role in analysis. Extensive anonymisation could risk losing particulars that made a difference. However, in my experience, it highlighted similarities and differences at concrete and more abstract levels. It also introduced a helpful distance for figuring out what mattered and what may be transferable to other contexts.

4.4 Casing practice change

Producing a practical social theory of SSD practice change (2.3.4) was an emergent, unpredictable and creative process dependent on deep engagement

and multiple judgements. Analysis began with the research idea and was ongoing through framing the question (chapter 1), setting the research scene (4.2) and producing the primary data (4.3).

Although this could apply to any research, particularly qualitative, the critical realist orientation introduced two subtle distinctions. Firstly, I lacked the security of a set path because reality (rather than method) was the reference point. This demanded reflexivity and opening up every aspect to critique. Secondly, I was influenced by Maxwell's (2012) argument for as great a focus on connecting *data* as on categorising it (as opposed to the more prevalent practice of connecting *categories*). This resonated with Noblit and Hare's (1988) typology of reciprocal, refutational and line-of-argument translations when synthesising data. To account for these distinctions, I present analysis as overlapping actions: questioning, coding, modelling, narrating, and writing.

4.4.1 Questioning

Curiosity about practice and practice change was focused and refined through constant questioning of self, data and literature (2.2.4.1). Supervisors asked different questions of the data and how it was produced based on their knowledge, experience and outsider perspective on speech and language therapy. Questions had different purposes, and their nature also evolved as the practical social theory took shape.

A set of underpinning questions translated critical realism into practice (Figure 4-9). Question 1 incorporated analytical dualism of agency, structure and culture (2.3.2). Question 2 related to abduction (2.2.4.2), reminding me to test out different ways of framing, categorising and connecting data and ideas. Question 3 related to retroduction (2.2.4.3), in practice incorporating time ('what *has made* this possible?') and context ('what makes / has made it *not* possible?'). Question 4 highlighted the fallibility of all knowledge, reminding me to recognise and interrogate assumptions (2.2.1).

Figure 4-9: Underpinning questions
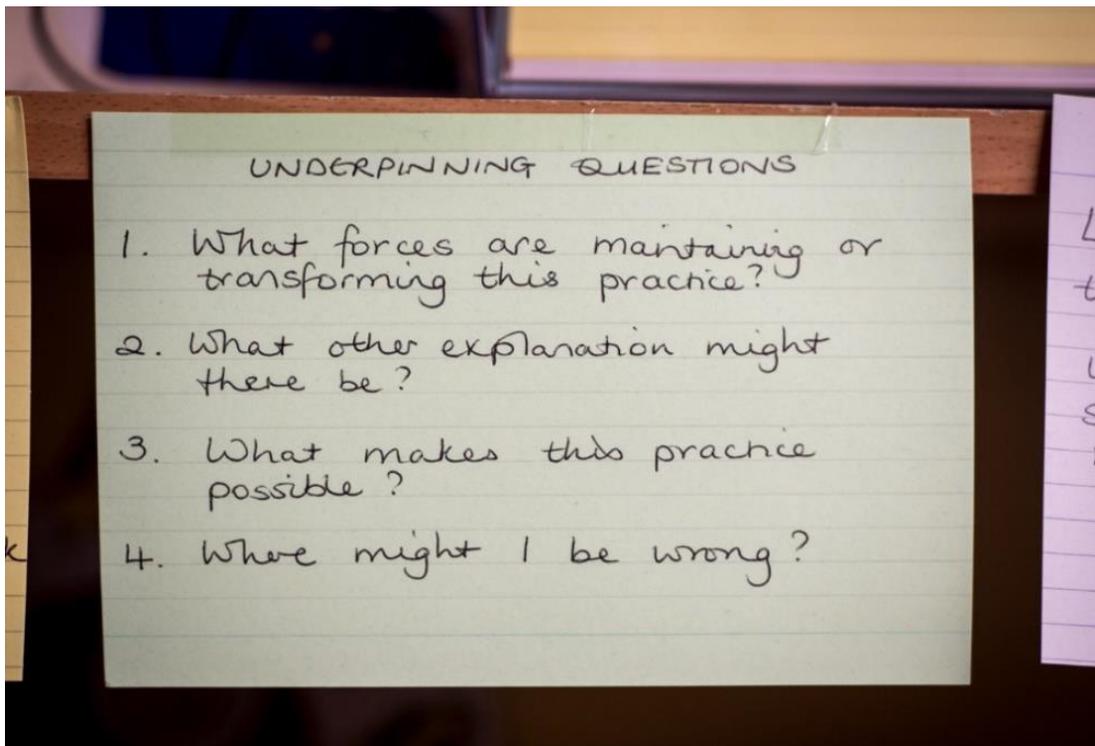
A second question set (Table 4-5) drew on Blaikie (2009) to operationalise the research question (*How and why have speech and language therapists changed their practice with children with SSD?*) within the explanatory framework (2.3.2). They helped me organise the data and proceed inductively. Noticing word choices, for example, assisted differentiation of intervention elements (chapter 6) and understanding why practice change was hard to describe (e.g. could something be 'new' when it was 30 years old?)

Table 4-5: Questions to describe data

- What range and types of practice change do these SLTs describe?
- What words do they use in relation to practice change?
- What historical and current contexts do they describe for these practice changes?
- Who (what people) do they describe as desiring these practice changes?
- What do they describe doing to make these practice changes?
- What supports for these practice changes do they describe?
- What reasons do they give for changing their practice in these ways?
- What reasons do they give for sustaining these changes?

In connecting the explanatory framework (2.3.2) with the empirical data, a third question set (Table 4-6) provided prompts for writing (4.4.5).

Table 4-6: Questions to prompt writing

1. What practice is entrenched and why, and what are the invisible strings (architecture) holding this in place?
2. What social arrangements support practice change and why?
3. What is it about particular interventions that might make them more or less straightforward (or possible) to consider and use?
4. How can this understanding help us re-imagine 'eclecticism'?

4.4.2 Coding

I used purposeful coding to organise and reduce data by allocating it to categories (Spencer et al. 2003) and to scaffold the flow of data ideas (3.3.3) in relation to aims, people, context and theories. Four coding examples follow reflecting that, as recorded in a memo (29th March 2016):

> At some points it is good to look for particular things, at others it is better to immerse in a section and think about lots of different aspects.

4.4.2.1 *Inductive coding*

I inductively coded one contribution which encapsulated the core aims of the study based on contrastive experiences (Figure 4-2). Organised via NVivo 10 (Bazeley and Jackson 2013) and A3 posters, three preliminary mechanisms became apparent and shaped subsequent analysis (Table 4-7).

Table 4-7: Preliminary mechanisms shaping analysis

Preliminary mechanisms	How they shaped analysis
The same yet very different	What are the elements / levels of SSD intervention? How are they mixed and matched?
Re-thinking what is possible	What made *re-thinking* possible?
Expectations are real	What are expectations? What are their effects?

4.4.2.2 Coding using explanatory framework

A different contribution lent itself to analytical dualism (2.3.2) coding, as it showed depth of theoretical knowledge of interventions contrasting with the direction of the service. Inspired by the Voice-centred Relational Method (Mauthner and Doucet 1998), using 'I' where possible, I summarised the data in a Word table headed Agency, Culture, Structure and Normative. The inductively-derived final column exposed the 'internal conversation' mediating the Agency-Structure-Culture relationship (2.3.2.4).

So I could use the detail in this contribution to test the scope of others, a second summary table coded:

- Interventions, assessments, influencers
- Potentially modifiable aspects of interventions
- Contextual tensions / compromises (ideal vs real)
- Social forces

4.4.2.3 Coding to establish the phenomenon

From 4.4.2.2, I realised a contribution matrix would help establish the practice change phenomenon and inform summaries (4.4.5). Three iteratively developed columns covered practice changes, topics, and particular contribution. Entries were paraphrased from stretches of talk and involved varying degrees of inference, e.g.:

- "there's been a SIGNIFICANT change in the way that I work"
- "this was"... "and I kept"… "and I knew" (past tense) "whereas NOW"

I started all practice change summaries with gerunds (becoming, picking, trying, ending) to emphasise action and connections (Charmaz 2006). I started topic summaries with nouns (rationale, perception, impact), which allowed for emotional depth (irritation, honesty, passion).

4.4.2.4 Coding to round out an aspect of the theory

Once 'Caseload' (chapter 8) became a key aspect of the practical social theory, its high specificity meant it was most efficient to connect my ideas with data by automatic text searching, then coding to an NVivo node. I exported these segments to Word and organised them inductively with descriptive headings.

After printing the resultant 32 groups, I re-organised them manually (using scissors and sellotape) until I could identify emerging themes to explain this aspect of the practice context. This formed the basis for writing a findings chapter (4.4.5).

4.4.3 Modelling

Constant questioning of self, data and literature (2.2.4.1) prompted an overwhelming and multi-layered range of ideas about what might be going on. Ideas can be transient, tacit, and difficult to express in words. Making, using and refining visual models in conjunction with other analysis tasks enabled me to capture, condense / expand, test out and communicate these ideas and how they might be related. As Clarke (2005) notes, this approach also draws attention to what might be missing:

> In seeking to be ethically accountable researchers, I believe we need to attempt to articulate what we see as the *sites of silence* in our data… How might we pursue these…*without* putting words in the mouths of our participants? (Clarke 2005, p.85)

Models varied from low tech doodles and diagrams on paper to commissioned graphic design products. The now defunct NVivo modelling tool offered an opportunity to play with ideas through moving, grouping, splitting, merging, shaping, naming, sizing, colouring and connecting visual representations.

Here I will include six examples of models which paved the way for the final models of SSD intervention and practice change. The professionally designed study logo captured the sociological nature of the study, as it showed people contributing to moving and integrating abstract things (Figure 4-10). I used the logo on all recruitment material to orientate potential participants and stimulate thinking.

Figure 4-10: Logo

The nodes model (Figure 4-11) followed inductive coding of an interview (4.4.2.1). This separated Caseload from Intervention practice, differentiated SSD from other jurisdictions, and drew attention to different kinds of work in practice change.

Figure 4-11: Inductively-derived nodes model
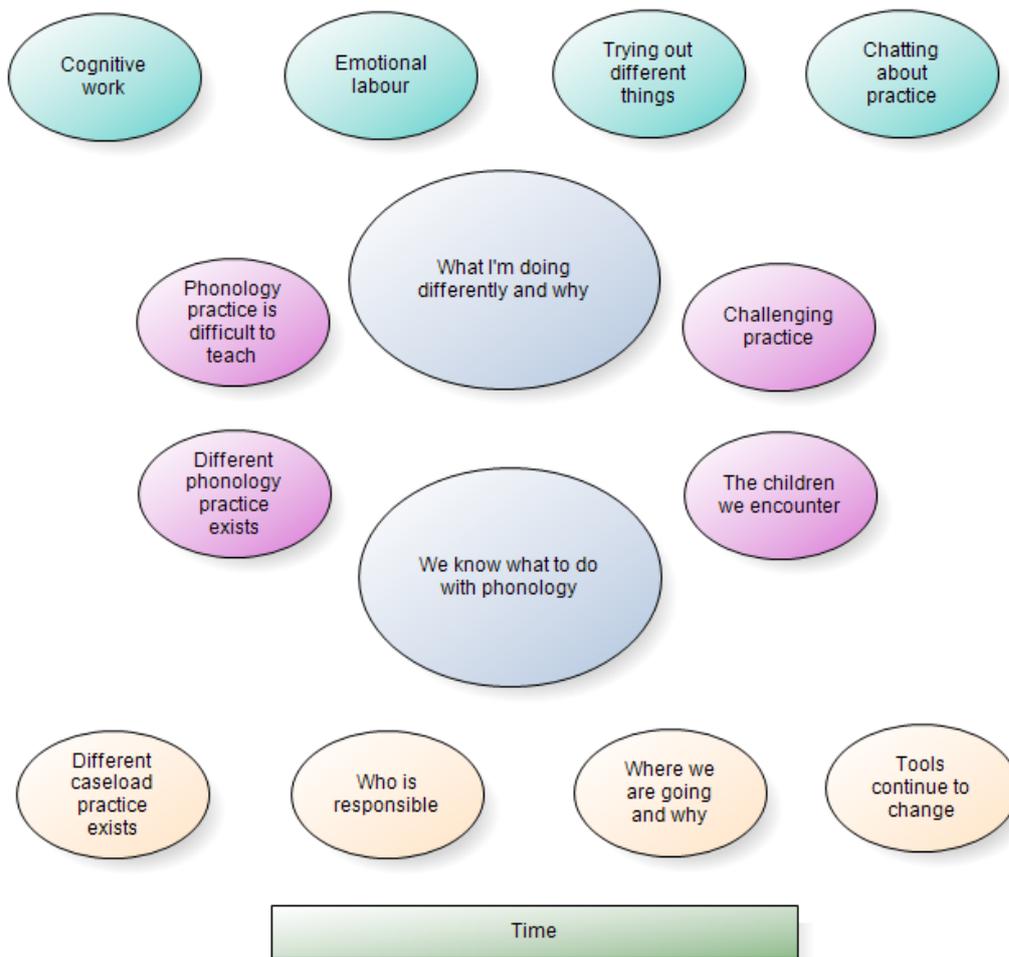
Figure 4-12 was an early map of intervention elements which were open to change. It informed the decision to focus on the specialist level of SSD intervention. Figure 4-13 was a late example of a model to integrate the explanatory framework (2.3.2) and the data as a whole. I used this to index the data and organise writing (4.4.5).

Figure 4-12: Early model of intervention
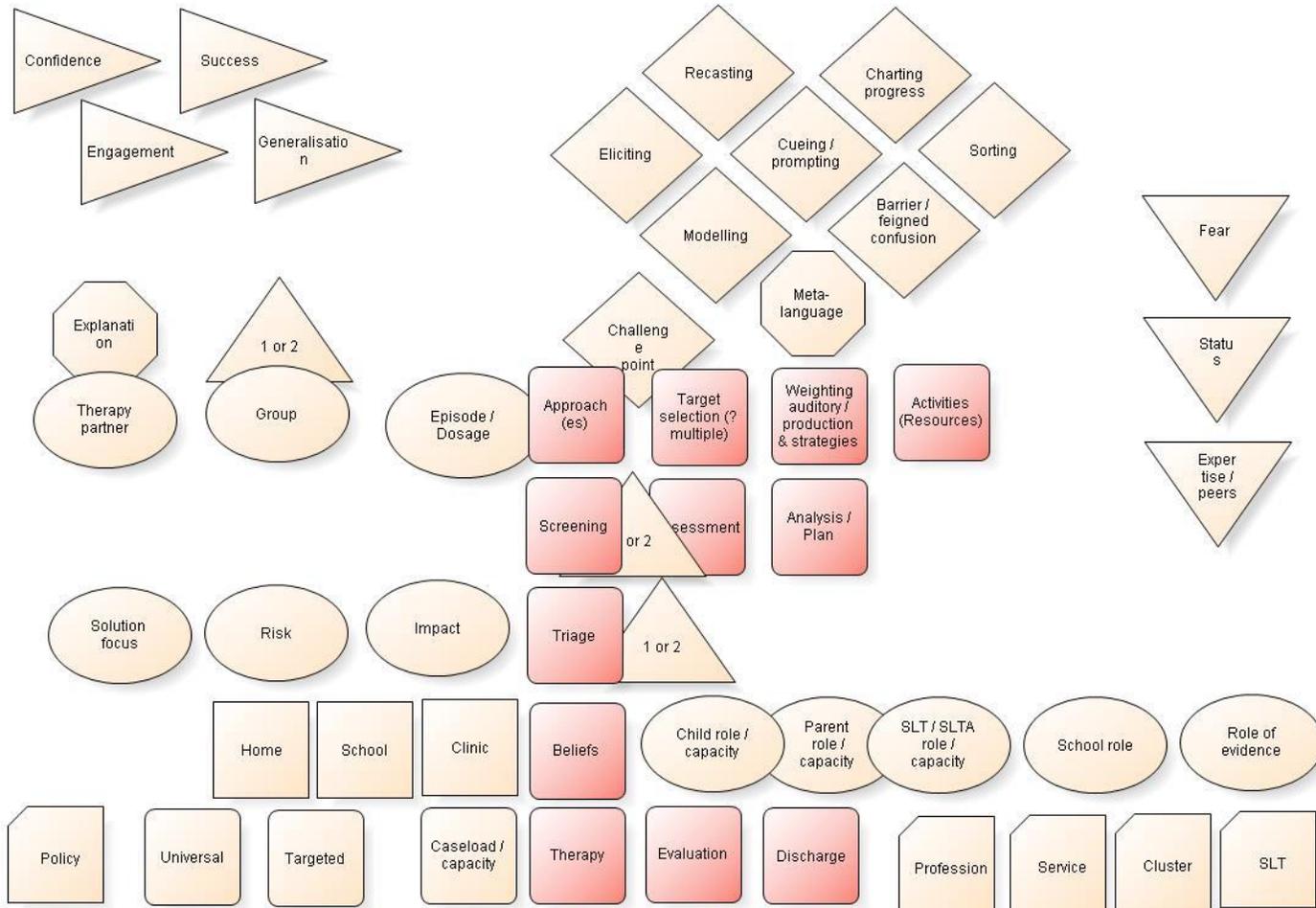
Figure 4-13: Index model
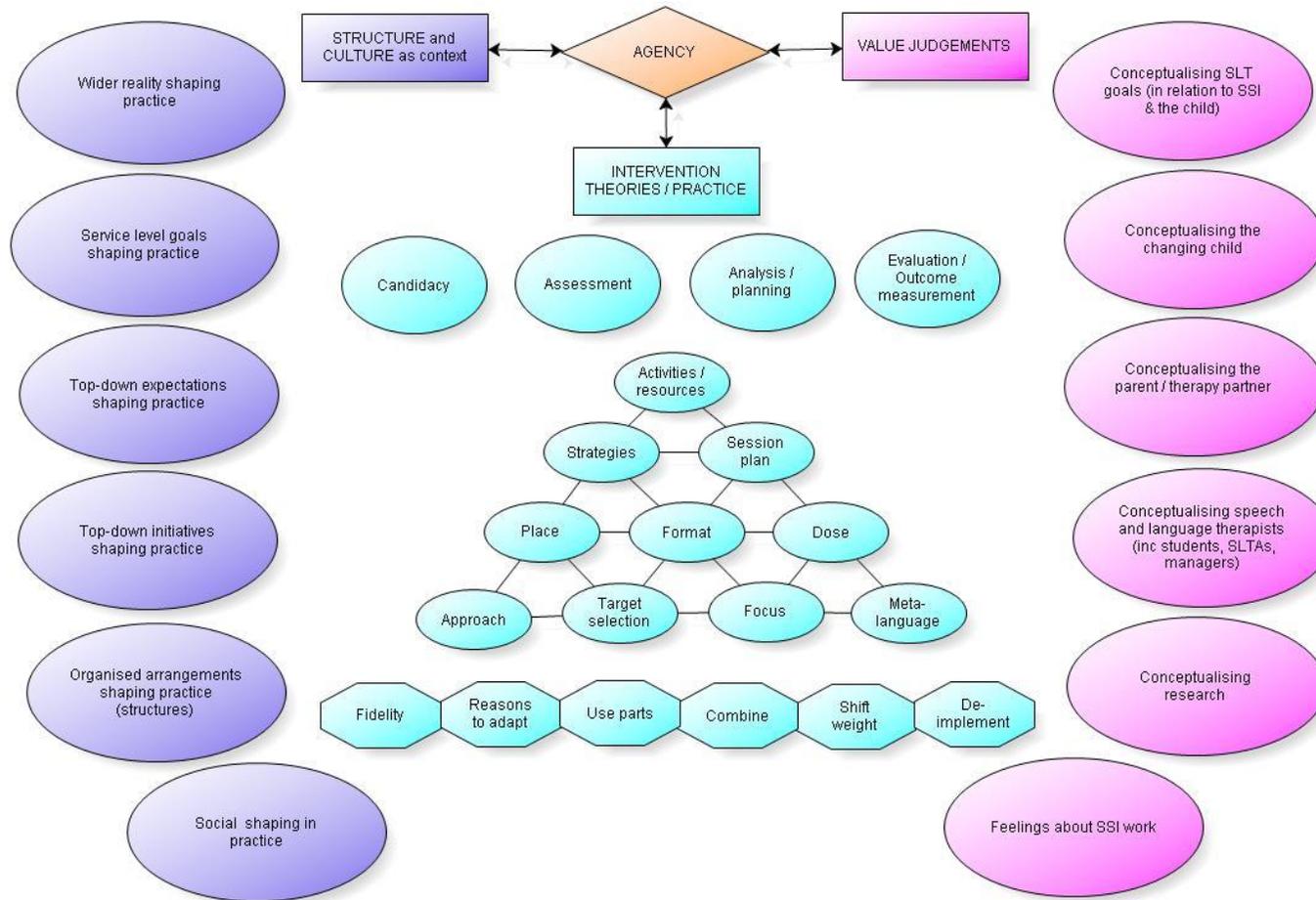
The initial sketch of aspects of the practice context (Figure 4-14) emerged while writing around Dosage of intervention (6.3.3).

Figure 4-14: Practice context sketch

Caseload	Service
Case (child)	Intervention
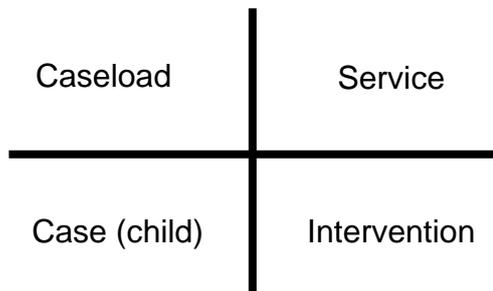
Figure 4-15 helped me configure the cases of practice *change* by mapping the historical context from which all these cases had ultimately emerged (T1 in Archer's basic morphogenetic sequence (Table 2-2)).

Figure 4-15: Historical context for cases of practice change
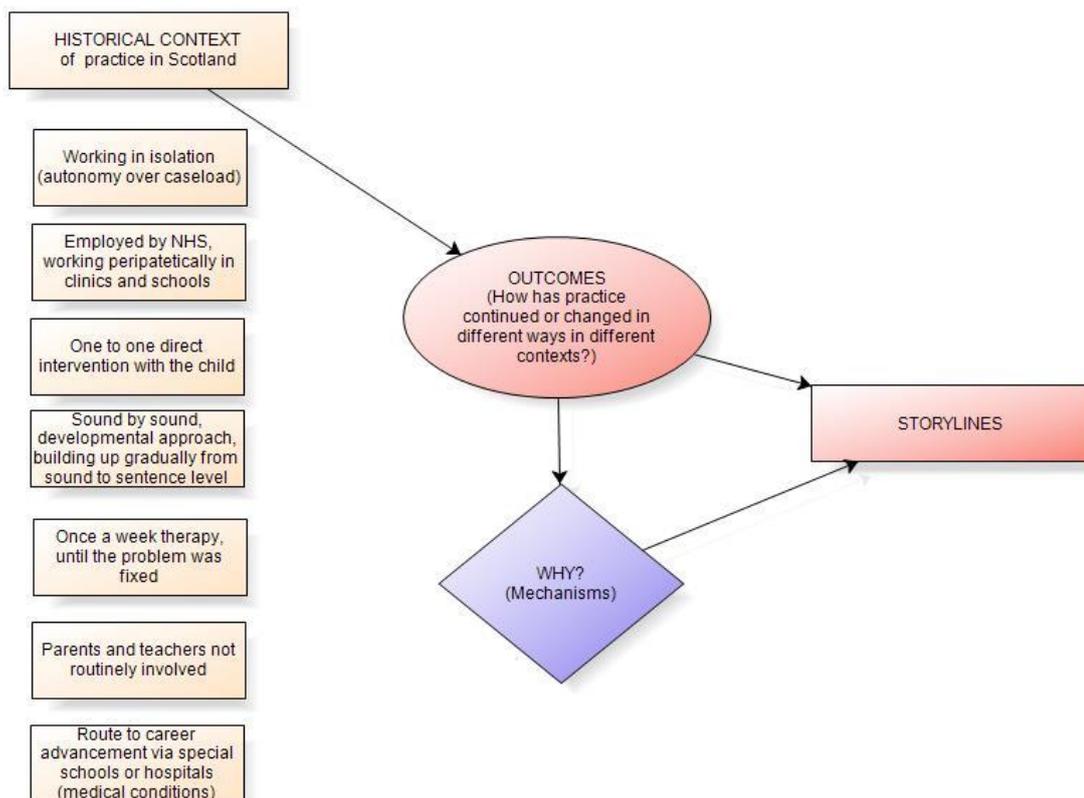
The final graphically designed models remain provisional. They include the ten changeable and layered elements of SSD intervention (Figure 6-1), and the theory of SSD practice change (Figure 5-1).

4.4.4 Narrating

In this section, I will show how ideas coalesced in the form of ethnodramatic monologues. These contributed both to explaining the cases of practice change and to sharing the research findings.

As I wrote around Dosage of intervention (6.3.3) and reflected on interviews, I heard competing voices in my head. These were not specific to individuals or services but threaded through them as narratives. I realised they could help explain why practice change had followed one trajectory rather than another.

At the time, I was planning a presentation of early findings to a clinical academic speech and language therapy audience. I wanted to ensure they understood rather than judged their colleagues' perspectives. I recalled Noblit and Hare's (1988, p.77) argument for experimenting with expressing syntheses in different ways, including drama:

> The entire point of approaching synthesis as a comparative translation is not to achieve closure, but to enable discourse. An audience-appropriate synthesis is one that enriches and enlarges the audience's discourse.

Bringing these ideas together, I worked up the narratives as short monologues. They were grounded in word choices, phrases and reasoning of participants, and incorporated my interpretation of how this particular narrative had come to be and was being held in place. Drawing on teenage experience of theatre workshops that included writing and performing, and memories of performances by a midwifery theatre company, I honed the monologues to incorporate tone (e.g. resignation, empowerment), Agency and Culture ('I' or 'we'), and to communicate as everyman[21] reflections.

To preserve the impact of this technique, I restricted it to the three competing narratives which stood out in terms of explaining practice change: Dosage (Figure 6-3), generalisation (Figure 6-2), and expectations (Figure 9-2). The monologue development was rigorous but messy, involving constant questioning (4.4.1), writing, reading aloud and revision. Figure 4-16 is an early example of scribbling to test out narratives around expectations.

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[21] In the sense of an ordinary or typical speech and language therapist

Figure 4-16: Scribbling expectations narratives

When this thesis was nearly complete, I discovered that writing ethnodramatic monologues is a genre (Saldana 2011). Structurally, my monologues fitted the arc of:

> …reveries in which no specific action progresses forward, but the audience learns about the history, opinions, values, attitudes, and beliefs of the participant/characters (pp.68-69)

Whether this aspect of the analysis is a strength or limitation may depend on the standpoint of the reader. If you believe the credibility of qualitative findings depends on *direct* quotations of participants, this is likely to be uncomfortable. To me, it is a genuinely sociological approach that holds considerable promise for research translation.

4.4.5 Writing

As a form of creativity using language, writing was not only *about* analysis but part of the method of inquiry:

> *Thought happened in the writing.* As I wrote, I watched word after word appear on the computer screen – ideas, theories, I had not thought before I wrote them. Sometimes I wrote something so marvelous [sic] it startled me. *I doubt I could have thought such a thought by thinking alone.* (Richardson and St. Pierre 2005, p.970)

Fragments in the form of scribbles, memos, questions, notes, records and diaries helped me make connections, notice non-connections, and remember these. Summaries of transcripts, concepts and context helped distinguish layers and how they were interrelated, allowing what was most germane to the research question to emerge. Writing monologues (4.4.4) connected analysis to what would resonate with the intended audience. Writing and re-ordering headings and sub-headings from the data helped develop the model for indexing it (Figure 4-13).

The fragments, summaries, monologues and models fed into more substantial pieces of writing intended as findings chapters. I started writing about the index model (Figure 4-13) from its core, the base layer of ten changeable intervention elements. By the time I reached Dosage (6.3.3), the nascent theory began to take more shape (Figure 4-14), in particular the importance of Caseload and Service as independent aspects of the context for practice change. Through writing about the top blue section in the index model, the logical grouping of the four components as Candidacy (distinct from Intervention) became clear, as did its better explanatory power in relation to practice change than the provisional category of Case (child). Rather than retaining the chapter on adaptation of intervention (the six blue octagons in the index model), I used it to inform case configuration. The purple components of the index model prompted writing

around structural and cultural aspects of Services. Rather than writing specifically about the pink components (value judgements), these informed all writing through supporting constant questioning of self, data and literature (2.2.4.1) as well as imagined conversations between different participants, services and audiences based on the data.

As all original findings chapters were lengthy and detailed, they had to be substantially condensed and focused. I had to decide what to amplify and what to dampen to present the configured cases with their best explanations, taking into account what might achieve a 'that's interesting!' response from different audiences (Davis 1971) (2.2.4.1).

4.5 Judging validity

With critical realism, validity is judged in relation to reality, which can never be fully known (Maxwell 2012). This meant I gathered and analysed empirical data in a responsive and flexible way, continually questioning whether this strengthened or threatened the validity of my conclusions. To illustrate this approach with an example, I will return to realist sampling (4.2.1). The validity of the decision to stop interviewing at 42 participants out of the 56 volunteers cannot be judged in isolation, as it built on previous decisions including:

Decision 1: A maximum not a target (50 participants)

- Supervisors suggested this was 'about right' for the academic and practical requirements of a PhD, and it was a sociological rather than psychological study
- I could give departments and Research & Development an indication of how many staff and how much staff time might be involved
- It built in flexibility to respond to the iterative nature of the study

Decision 2: Varying the distribution from the three NHS areas

- Fewer potential participants in [Clootshire] than I had anticipated
- [Blaeshire] volunteers included self-generated focus groups (i.e. higher numbers per encounter)

- [Blaeshire] offered more explanatory power as more practice change had taken place and there were clear sociological implications

From a critical realist perspective, all knowledge is partial and fallible, so a decision about when there was 'enough' data to help answer the research questions depended on judgement. To confirm 42 was an appropriate place to stop, I tested my data against the Information Power Model (Malterud et al. 2016), a 5-item tool for critical reflection on sample size decisions in qualitative research. The left end of each continuum indicates higher information power / smaller sample size, while the right end indicates lower information power / higher sample size; the bold descriptor is my judgement of where this study fell and is followed by a justification for that choice.

1. Study aim (narrow to **broad**)

Asking about 'experiences of practice change' is fairly broad, but was narrowed by relating it to children with SSD.

2. Sample specificity (**dense** to sparse)

All participants had highly relevant experiences, particularly in [Blaeshire] where there were relatively more participants, including focus groups.

3. Use of theory (**applied** to not)

Theory is integral to all aspects of this study.

4. Quality of dialogue (**strong** to weak)

The analytic value of the interview and focus group data was strong. Average length was 1 hour 18 minutes, with almost none of this irrelevant. I was also able to discuss developing theories with participants.

5. Analysis strategy (case or **cross-case**)

A connecting and categorising 'casing' approach was used.

4.6 From 'What I Did' to 'What I Found'

This chapter brings Section I (What I Did) to a close. It showed how I put the research question to work in the primary study using the methodological

principles outlined in chapter 2 and findings from the qualitative synthesis (chapter 3). Having set the scene through realist sampling, successful recruiting and ethical thinking, the primary data was produced through interviewing participants and transcribing and anonymising audio material. A variety of analysis tasks - questioning, coding, modelling, narrating and writing - all contributed to the theory of SSD practice change (chapter 5). I also demonstrated how I dealt with threats to validity with an illustrative example.

Having discussed 'What I Did', Section II presents 'What I Found' as a result. This includes a 10-element model of what can change in SSD intervention, and work in four aspects of the practice context (Intervention, Candidacy, Caseload, Service) which together explained six different cases of practice change.

Section II: What I Found

5 Introducing the theory of SSD practice change

Section I started with the research problem of a gap between expectations and reality of practice change, and a proposal to investigate how practice *had* changed through turning a theoretically-informed implementation-practice-profession lens on the speech and language therapy jurisdiction of children with SSD. Chapters 2-4 described how I operationalised this to understand what practice change is, the work it really takes, and why there are different trajectories of change. This included taking a theory-informed approach to a qualitative synthesis and a primary case-based study where I asked 42 speech and language therapists from three NHS areas and private practice in Scotland how and why they had changed their practice with children with SSD.

Section II reports what I found in the form of a practical social theory, which others may wish to draw on when planning an implementation project. Although the analysis reported in Section II mainly relates to interview and focus group data, it is integrated with sensitising theories and literature and the qualitative synthesis. The resulting 'theory of SSD practice change' (Figure 5-1) is my best explanation at this point of how and why, from an integrated practice perspective, specialist speech and language therapy for children with SSD had come to be one way rather than another.

Figure 5-1: Theory of SSD practice change
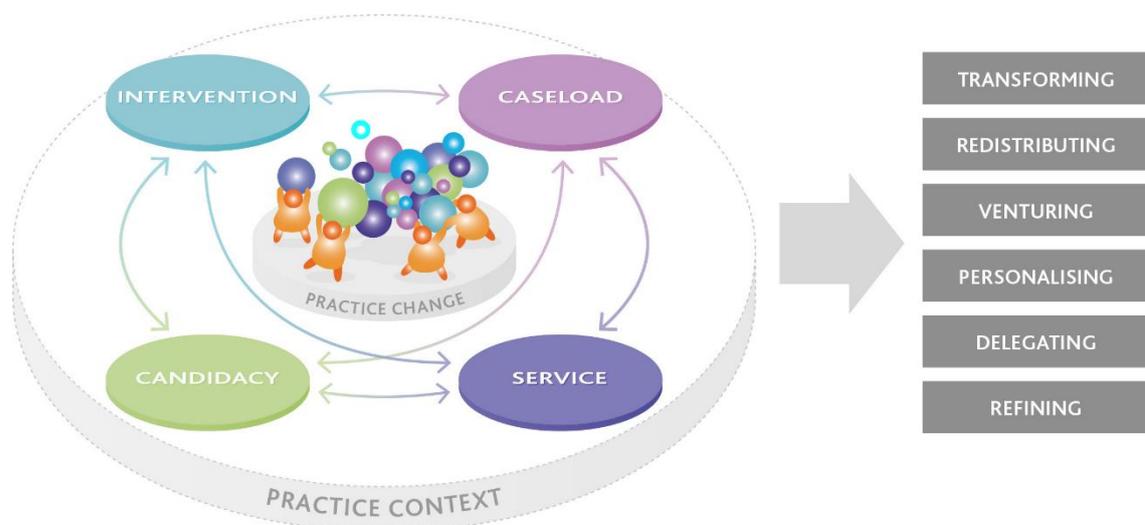
This chapter offers an overview of the theory of SSD practice change, which is then explored in detail in chapters 6-10. Chapters 6-9 discuss the work participants had put in to the four identified key aspects of speech and language therapy practice (Intervention, Candidacy, Caseload, Service); this provided the immediate professional context for practice change. Chapter 10 reveals how, when the work of these key aspects was considered in an integrated way, it patterned to explain six different cases (trajectories) of practice change (Transforming, Redistributing, Venturing, Personalising, Delegating, Refining).

In 5.1 I will introduce the four key aspects of speech and language therapy practice which provided the context for practice change, and provide a rationale for my choice of labels. In 5.2 I will give a summary description of each case of practice change and a visual representation of the different work patterns underlying its trajectory. I will also posit key mechanisms which would need to be invoked if other services wished to transfer that case, in the sense of making it happen in their own context (2.2.2). To provide a further reference point, all terms used in the findings are also defined in Appendix 8.

5.1   Key aspects of practice providing the context for practice change: Intervention, Candidacy, Caseload, Service

The trajectories (cases) of practice change were made possible over time by individual and collective work that differentially modified key aspects of the immediate practice context: Intervention, Candidacy, Caseload and Service. The word choices for these aspects marry the empirical work and practical purpose of the theory of SSD practice change with the rich theoretical resources provided by the social sciences. This interplay is introduced briefly here and explored further in chapter 11.

'Intervention' is borrowed from applied health services research, where healthcare professionals are viewed as using interventions with multiple interacting and specifiable components (Clark 2013; Craig et al. 2008). Participants discussed their therapy more holistically and identified with the idea of eclecticism. However, as codified in Normalisation Process Theory (1.2.1.4),

Differentiation is a vital component of sense-making Coherence work. To help practitioners reflect collectively on what components could potentially be modified, and the type of work this might take, 'Intervention' appeared the best fit.

'Candidacy' appropriates a construct generated through a critical interpretive synthesis of evidence about the work of accessing healthcare (Dixon Woods et al. 2006). I noticed that participants talked about a variety of tools and practice changes impacting on their decisions about the who, when, where, how and why of entering, staying in and exiting the service, but this gained theoretical coherence when I read about Candidacy theory. Some participants acknowledged discomfort around who might be disadvantaged by their decision-making, and construing this as 'Candidacy' work draws attention to its political, moral and under-theorised nature.

'Caseload' really mattered to participants and is the term they used. Clinical caseloads were made up of 'cases' (people judged to have Candidacy) but were also a whole. As caseloads belonged to a therapist and also to a Service, they were a site of tension for practice change. In spite of Caseload's pivotal role for trajectories of practice change in the SSD jurisdiction, and its potential for modification, the academic speech and language therapy literature is almost silent on it as a theoretical construct. Raising its profile opens up new avenues for comparative research with other professions where caseloads are also core to their practice.

'Service' was chosen because, whatever other professional influences were at play, this aspect profoundly influenced what was acceptable as practice change and the resources available to support the necessary collective work. The different approaches taken to resourcing practice change suggest that tools informed by implementation theory could prove useful, and that the theory of SSD practice change could be a helpful adjunct. Such tools include NoMAD, a measure developed from Normalisation Process Theory (Finch et al. 2015), and i-PARiHS, derived from PARiHS to help operationalise facilitation (Harvey and Kitson 2016).

5.2 Cases of practice change, patterns of work, and key mechanisms

The theory of SSD practice change shows six cases as trajectories of practice change emerging through individual and collective work in four key aspects of the immediate practice context: Intervention, Candidacy, Caseload and Service. As configurations, the cases do not correspond directly with particular individuals or services who participated in the primary study or were represented in the qualitative synthesis, but draw on their reported experiences to refer to a deeper social reality.

The cases are labelled as ongoing actions (Transforming, Redistributing, Venturing, Personalising, Delegating, Refining) because practice change is not a stable outcome but a dynamic process which is open to influence. Summary descriptions of each case are in the first column of Table 5-1. Column two is a colour-coded visual representation of the patterns of work on Intervention, Candidacy, Caseload and Service that explained the different trajectories; the detail of this work is discussed in chapters 6-10. Column three posits the mechanisms which my analysis suggests would need to be transferred if services wished to replicate that case in their own setting; for the rationale, see chapter 10.

Table 5-1: Case descriptions, work patterns, and mechanisms

Colour coding key (column 2)
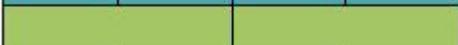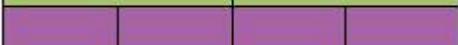
= Intervention work
= Candidacy work
= Caseload work
= Service work

Case description	Context work pattern	Key mechanisms
Transforming Non-traditional SSD interventions for selected children becoming part of local routine practice		• Pride in the contribution of unique linguistic skills to speech and language therapy effectiveness • A culture of external and internal facilitation

Redistributing Negotiated periods of intensive intervention for selected children with SSD becoming part of local routine practice		• Distributed agency over the logistical layer of Intervention • A culture of distributed decision-making that respects what different specialist knowledge can contribute
Venturing Individual or informal groups of therapists trying out or using interventions that are not part of local routine practice with selected children with SSD	?	• A culture of individual professional responsibility to provide more effective therapy within existing constraints
Personalising Highly personalised intervention becoming part of local routine practice with children with SSD		• Privileged access to the family
Delegating Specialist SSD intervention via a therapy partner becoming part of local routine practice	x	• Desire to provide an equitable service within constraints • Doubt about potential return on investment in SSD at the specialist level
Refining Individual or informal groups of therapists making ongoing adjustments to intervention for children with SSD		• A culture of professionalism as a personal commitment
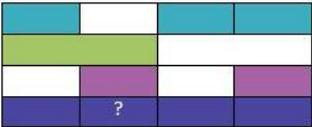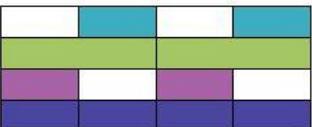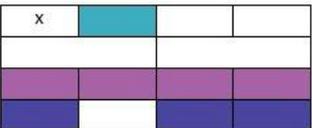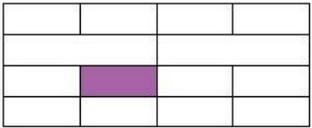
5.3 From summary to detail

This chapter has provided a brief overview of the theory of SSD practice change. Chapters 6-9 report the Intervention, Candidacy, Caseload and Service aspects of the practice context for the trajectories (cases) of SSD practice change in detail with illustrative quotes from participants, while chapter 10 discusses how I integrated this data to configure the six cases.

6 Intervention aspect of the practice context

6.1 What can change in SSD Intervention?

The way participants talked about SSD intervention suggested it is highly complex to define, explain, do and change. As a dynamic act, it was personal and experienced holistically, but also made up of interacting parts. There was a growing realisation that 'interventions' was plural, and that changing intervention might offer genuinely different options.

To identify order in the complexity, and communicate the work incurred by parts and the whole, I derived a model of what can change in SSD intervention using the methods in chapter 4 (Figure 6-1). The model comprises ten elements in four layers. From bottom to top row, intervention incorporated ideas about SSD (theoretical layer), service delivery (logistical layer), and children (processual layer) along with what could be seen happening (observable layer).

Simultaneously, therapy had to have the power to make a difference to a child's speech; be provided somewhere, by someone, in a quantity; scaffold the (speech) behaviour change process; and be fun. SSD intervention - and therefore any *change* in it - necessarily involved intellectual, organisational, relational and creative work.

Figure 6-1: Model of what can change in SSD intervention
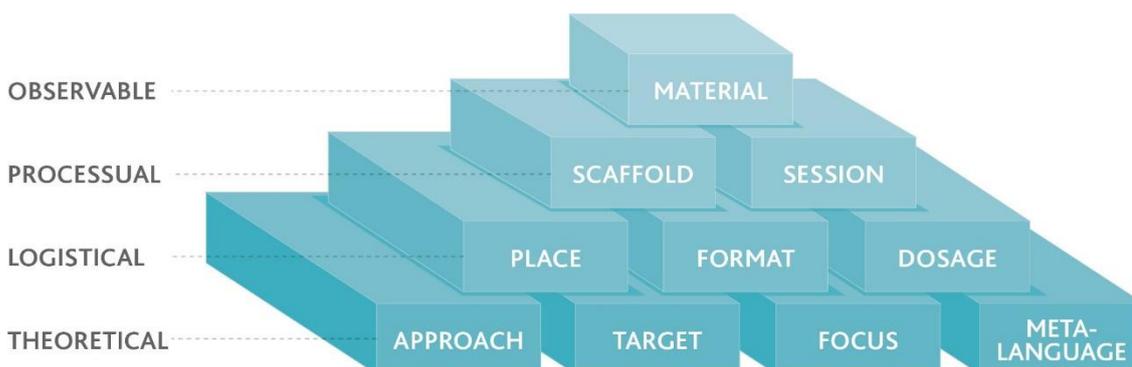
The model refers to what was potentially changeable in SSD intervention based on what participants reported they *had* changed and how this patterned. Practice change for individuals varied widely, but the model introduces

possibilities. For example, not all participants had experienced a change of intervention Place, but practice change had included where children were routinely seen (at a clinic, school, or at home). Including Place in the model as a changeable element of intervention rather than something external to it makes it possible for therapists to notice it and consider the implications of retaining, actively using or changing it as an intervention component. Working definitions for each element of the model are in Table 6-1.

Table 6-1: Working definitions of changeable SSD intervention elements

Element	Working definition
THEORETICAL LAYER	
Approach	• The underlying theory of an intervention's power to effect change in a child's speech • In practice conflated with *named* interventions (which include an Approach *and* other elements)
Target	• The specific speech sound(s) and / or other linguistic units a child is exposed to within the selected Approach • May or may not correspond directly with anticipated changes in the child's speech
Focus	• What a child is asked to *do* in therapy tasks so the selected Approach and Target(s) can work their effect • Usually relates to a point(s) on the speech chain continuum from what the child is hearing through to what they are saying
Meta-language	• A shared way of thinking and talking about speech sounds and intervention
LOGISTICAL LAYER	
Place	• Where a child is seen for intervention
Format	• How people are involved in intervention • May be dyadic (child / therapist; parent / therapist) or triadic (child / therapist / therapy partner) • May be organised for an individual or a group • Can include delegation to a speech and language therapy assistant
Dosage	• The idea that quantity of intervention can make a difference • Refers to how much, how often, how repetitively, how regularly, how distributed, or for how long an intervention is likely to be needed to be effective
PROCESSUAL LAYER	
Scaffold	• How behavioural techniques are used to support progress
Session	• How elements of intervention are ordered and structured to meet the needs of a child in an allotted timeframe

OBSERVABLE LAYER	
Material	• The things those involved do or use to make participating in intervention interesting and fun (e.g. physical, floor or table-top games, drawing, play) • Can be bespoke or generic, home-made or commercially available, low or high tech

To set the scene for this chapter, 6.1.1 is a typology of intervention, while 6.1.2 explores eclecticism to show why parts and wholes matter for SSD practice change. Section 6.1.3 addresses the problem of named interventions, 6.1.4 considers intervention coherence and 6.1.5 introduces the model structure. In sections 6.2-6.5, I describe and differentiate the layers and elements of intervention before exploring why two types of intervention change were experienced more profoundly: using non-traditional interventions (6.6), and changing the logistical layer (6.7).

6.1.1 Intervention types

Participants grappled with how to differentiate and label their intervention(s). Many used 'traditional' as a descriptor and discussed practice change in relation to this. To help manage the diversity, I will report intervention as four overarching types: traditional, non-traditional, non-mainstream, and instrumental. Each incorporates named interventions.

Participants conceptualised SSD and its relationship with intervention through broad but not mutually exclusive categories of articulation, phonology, phonological awareness and psycholinguistics. Articulation was about accurate speech sound production. Phonology referred to the system of sounds that make up a particular language (and how they compare and contrast), and to the ways speech sounds can be put together to structure words in that language. Phonological intervention depended on knowledge of how a particular child's speech sounds were patterned, and how this related to the usual patterns of the language. Phonological awareness addressed the ability to manipulate words, syllables and sounds as general foundational skills for speaking and literacy. Psycholinguistic models hypothesised where the speech chain (from input to output) might be breaking down for a particular child, so that intervention could address the deficit; this could include articulatory and phonological elements.

Traditional intervention(s) maintained a historical attention to accurate speech sound production (articulation) whilst incorporating ideas around phonology, phonological awareness and psycholinguistics. [Sally] suggested this had changed within the last thirty years but not the last ten.

The *non-traditional* interventions in this study related to phonology and phonological intervention. They challenged participants' linguistic knowledge as well as its clinical application. As these interventions were heterogeneous and new to participants but not to the literature, they lacked an obvious group label. The tendency of some to refer to non-traditional interventions as 'The Caroline Bowen' exasperated others because Caroline Bowen's book, website and courses are compendiums of SSD interventions.

Non-mainstream denotes named interventions which do not have mainstream academic support[22] in relation to SSD but may be used in practice. *Instrumental* intervention refers to high-tech visual biofeedback tools which are almost exclusively situated in universities. Both received relatively little attention from participants and - somewhat ironically - performed the same role in casing practice change.

Named interventions within each of the above categories helped make differences in what could be done more visible, but were also problematic. This is examined in 6.1.3.

6.1.2 Intervention as parts and wholes

The tension between intervention as parts and wholes was evident as I probed around participants' talk of eclecticism. I asked [Morven] if she had a name for her practice:

> (laughing) eclectic! (laughter).. is what it's called!! (laughter) I think.. I think what you learnt at [undergraduate institution].. is your basis in THEORY.. but lots of what you actually DO is what you have SEEN and ABSORBED as you've WORKED.. throughout your CAREER. [[mm]] And what's WORKED for you. (pause) [[yeah]] (long pause) I'm not sure [undergraduate institution] TOLD you how to treat the child!! (laughs)

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[22] This sidesteps the thorny but tangential problem of what constitutes sufficient evidence for an intervention, and who gets to decide

For [Sonia], eclectic didn't mean "a bit of that and a bit of this" but a thoughtful combination that "amalgamates.. em.. into the WHOLE really". Although [Elizabeth] worried eclecticism might disguise a lack of theoretical coherence, she had grown to value the unwritten wisdom accumulated in practice. [Emily] first encountered this as a student:

> they're all really SIMILAR, though, I always found, [[right]] it's just there's always elements that are.. slightly different.. and when you went into practice on your placements.. and you're like 'so:.. which approach are YOU using?' they go 'oh well I use a combination' (pause) em.. so that was sort of my learning of 'oh you don't HAVE to use just one or the other religiously.. it's.. it's about what works'

This reality of practice put [Aileen] at odds with research efforts to specify interventions:

> the more (laughing) I think about it, the more I realise it's a TOTAL mixed BAG that I'm using.. all the time.. and I think that's why... I-I know.. we had a recent study day where they were talking about the 'What Works'.. database? Em.. the Communication Trust one.. and folk were kinda saying it's really hard to tease out 'THAT'S the approach that I am (laughs) using'

Being introduced to non-traditional interventions led [Fran] to question previous assumptions. Although therapy was "all ABOUT being eclectic", there was a tension between "LOTS of different THINGS. In ONE." and *knowing* what had worked:

> You very rarely would just sit doing whole.. hour, working on Stimulability. (pause) But maybe I SHOULD. And that was something I WAS thinking about. Cos I tend to use lots of DIFFERENT things em.. and if I'm not seeing a lot of movem- I'll do a bit of clapping in with that, you know like LOTS of things em.. and then you-you don't know what's worked, or what's MADE it work or.. not work, cos if you kinda continue to do the same sorts of things.. would that have been more effective than you trying to do.. lots of different wee things...

[Elizabeth] felt she was becoming more "pragmatic" with experience, and [Sally] observed that, although therapists could start with a preference for working on groups of sounds or specific sounds, "the longer you've worked, the more likely you are to have a pick and mix." For [Louise], the meaning of eclecticism had been reshaped over her career. Knowledge was now collated and accessible

rather than held solely within practice experience. She had grown more "SAVVY" about the role of evidence and what was known about effectiveness. Historically eclecticism was "how you do things" or "what you KNOW at the time". Now, with more reference points and frameworks to draw on, SSD decision-making made more sense. However, as she joked, for practice change this brought risks:

> it CAN (laughing) actually make you feel 'OH my GOODNESS!!'.. [[yes]] ... 'what ARE we going to.. DO?' (laughs) [[yeah]] 'with this child.. let's.. let's just work on <s>!!!' (laughter)

6.1.3 The problem of named interventions

Although named interventions offered one way of seeing intervention as a whole, they were also problematic. On the one hand they could make theoretical and practical distinctions more visible and communicable, but on the other could obfuscate intervention complexity. Each named intervention offered a particular package, leaving participants uncertain about parts and wholes, and the extent to which they should do it 'by the book'. In addition, how thoroughly named interventions were understood and used was influenced by how they had been accessed: through literature or books, as a commercial package, as an internet summary, or as fragments in informal circulation.

Metaphon was the best example of how a named intervention could be reduced to different parts in different ways by different therapists. Some participants described their practice as if it incorporated Metaphon, while reporting they no longer used it. [Sophie] clarified that Metaphon was "that stuff that came in the plastic suitcase". This made it possible for her to continue to "TALK about those FEATURES and.. like you do long and short and front and back.. within other approaches" without seeing this as Metaphon. While [Elaine] felt grouping sound contrasts through Metaphon was a way to effect "quite QUICK change rather than teaching one phoneme and then.. either expecting generalisation or having to go on to the next phoneme", others taught Metaphon concepts but then worked on single sound contrasts. [Sally] used Metaphon concepts for structural SSD such as final consonant deletion where a production focus would be ineffective, but found it unnecessary for systemic SSD. Only [Sally] was explicit that the feedback practice of "kid says it, you point to the one that they

said, whether it's right or not" was associated with Metaphon, with other participants such as [Elaine] terming it "a minimal pair approach" through "a barrier".

6.1.4   Making intervention coherent

Intervention work includes maintaining coherence of the whole, even as elements are changed. The ethnodramatic monologues which helped me identify the three Target dimensions relevant to practice change are a good example (Figure 6-2). They came out of recognising that, while generalisation of intervention to everyday speech is a marker of effectiveness, participants conceptualised it differently.

Figure 6-2: Intervention coherence

Generalisation? Well, that's the final part of the process for a child with a speech problem, and usually the point I put them on review. It's really important that the child's ready for each stage of therapy when it comes, and that they - and the parents - experience success to keep them motivated. So I build up gradually, from them using the target sound in isolation, to consonant-vowel, word, phrase and then sentence level. By that time they're ready to transfer their learning to when they're talking in real life situations. This takes practice and gentle reminders, which really has to come down to the parents. It's a traditional, developmental approach, with a lot of practical wisdom in it. And, as my more experienced colleagues say, at least we know it works, even if for some children it takes years.

Generalisation? Well, that comes from equipping a child to communicate effectively in real-life situations, and to feel better about their talking. So I base therapy around the child's world, and what matters to them, because that way it's meaningful and motivating. Are there words they want to be able to say more clearly? Are there particular situations where poor intelligibility causes problems? Do they have a special interest that could make them want to practise? A lot of it's about building a child's confidence to cope with tricky situations - to realise what they CAN do and what strategies they could try. I find rating scales a useful way of helping a child to self-monitor, and to get parents involved in setting goals and noticing progress. I'm a very practical person, and I guess you'd call it a functional approach.

Generalisation? Well, when I said it there I meant linguistic generalisation. You plan for it from the start but have to resist that temptation to get on with something obvious, like 'Oh they're stopping fricatives, let's work on <s>'

because that's not where your therapy head goes any more. Instead, you work out what's really going on with that particular child's speech so you can get the targets right and tip changes throughout their sound system. I do have higher expectations of children now as I'm doing things like working on sounds they can't make, and that develop later. But I also have higher expectations of myself and what I can offer by combining my therapy skills with my linguistic knowledge. A complexity approach isn't really about having one approach to therapy and tweaking it for different children. It's about taking the time to do an in-depth linguistic assessment and analysis, and understanding when it's appropriate to select complex targets.

6.1.5 Intervention layers and elements

The model of what can change in SSD intervention reimagines eclecticism as interacting, coherent parts and wholes. It offers an opportunity to map named interventions, appreciate the complexity of intervention, and understand what practice change would involve.

My analysis suggests each layer exists simultaneously but necessitates a different kind of work. In practice, therapists have to reconcile their ideas about the underlying power of the intervention to effect change in communication (theoretical layer) with those about service delivery (logistical layer), children (processual layer) and what they will use (observable layer) as well as with the rest of the practice context. Each element exists in relation to the others, but with different and diverse dimensions relevant to practice change (Table 6-2).

Table 6-2: SSD intervention change model structure

Layer	Element	Key dimensions of change
Theoretical	Approach	Traditional / Non-traditional
	Target	Traditional / Functional / Non-traditional
	Focus	Traditional / Non-traditional / Non-mainstream
	Meta-language	Specified / Personal / Unspecified
Logistical	Place	Locally conventional / Locally unconventional
	Format	Conventional / Unconventional
	Dosage	Conventional / Unconventional
Processual	Scaffold	Congruent / Incongruent
	Session	Routine / Non-routine
Observable	Material	Adaptable / Individual / Personal

This model constitutes the Intervention aspect of the practice context for SSD practice change. The following four sections provide further detail on the scope of each layer and element based on experiences across the whole sample.

6.2 Theoretical layer of intervention

While every layer of the SSD intervention model involves theories, the theoretical layer is distinguished by its attention to speech sound development and disorder. SSD intervention has to have the power to make a difference to a child's speech, or at least to their communication. This involved a combination of Approach, Target, Focus and Meta-language.

6.2.1 Approach: traditional and non-traditional

All SSD intervention was underpinned by an idea about *why* it should have the power to make a difference to a child. Approach refers to this core theory behind what a therapist is doing. Ideally, participants selected an Approach for a particular reason, usually to match the perceived problem, and sometimes as a stepping stone.

Table 6-3 includes the four identified traditional Approaches and what the therapist had to *do* to effect each. It also lists the associated labels or named interventions, and who participants considered them suitable for.

From participants' accounts of practice change, I also disentangled six non-traditional Approaches. Table 6-4 lists each Approach (including what the therapist had to *do* to effect it), the best available label[23], who participants considered it suitable for, and the distinction that made it appealing.

As analysis was based on the approaches and named interventions as raised and discussed by participants, and this may or may not correspond with how they were intended to be interpreted or used, they are not specifically cross-

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[23] Named interventions Core Vocabulary, Cycles, Multiple Oppositions, and Stimulability were the best labels for four of the Approaches. Complexity subsumed the named interventions Empty Set and Maximal Oppositions, reference to Judith Gierut, and selection of linguistically complex Targets. Perception was an amalgam of one participant's discussion of Susan Rvachew's ideas, and references to the Locke test.

referenced with the research literature. Instead, the approximate decade of emergence in the literature is included, with further signposting in Appendix 9.

Table 6-3: Traditional Approaches

Approach (theory)	Name	For whom
Follows a highly structured process to **build up production**	Sound-by-Sound e.g. Van Riper (1970s)	Children with SSD
	Nuffield (1980s)	Children with dyspraxia or severe SSD
Draws attention to how **contrasts** between sounds make a difference in meaning to **reorganise** the system	Minimal Pairs (1980s)	Children with SSD
	Colour Coding (1980s)	Children with systemic SSD Children who know their colours Children and parents who find Metaphon concepts difficult to 'get' Training teachers (as a universal approach) Children with severe or persistent SSD who need speech made more visual
	Metaphon (1990s)	'Brighter' children with SSD, or those who don't also have a language problem Children with structural SSD, and children with systemic SSD
Teaches child to **recognise and manipulate** linguistic units (speech sounds, syllables, onset-rime) to **strengthen foundational skills** for speaking and literacy	Phonological Awareness (1990s)	Children with SSD All children (as a universal approach) Children with severe SSD, or who aren't making progress Complicated children, where you're not sure where to start
Thinks in terms of models and boxes to **address a specific breakdown in the speech chain** for the child (e.g. marking syllables, initial sound identification, silent sorting, rhyme generation)	Stackhouse & Wells / Psycholinguistic Approach (1990s)	Children with SSD Children who also have language difficulties

Table 6-4: Non-traditional Approaches

Approach (theory)	Name	For whom	What's different
Draws attention to how different sounds in a particular word position make a difference in meaning to **reorganise** the system	Multiple Oppositions (2000s)	For children with a phoneme collapse ('favoured articulation')	You're covering several contrasts at once
Exposes child to all consonants to **expand** the system at consonant-vowel / vowel-consonant level	Stimulability (1990s)	For young children with very few sounds in their sound system	You've got somewhere to start, and can start earlier; recognises that we do have to teach children to say sounds (articulation)
Uses linguistically complex targets to **push change down** through the system	Complexity (late 1980s)	For children with severe / disordered phonology	You're several steps ahead and backfilling
Establishes phonological consistency to **stabilise** the system	Core Vocabulary (2000s)	For children with inconsistent phonological disorder	You're not spending time working on things they don't need
Time limits exposure to each set of targets, to **gradually prompt** system change	Cycles (1980s)	For children with multiple entrenched phonological processes (mainly four or more substitutions)	You're working on a number of sounds at once
Exposes child to multiple exemplars of same sound, so they **extrapolate a robust construction** of it	Perception (1990s)	For children who realise (produce) the same sound in slightly different ways, or whose SSD is related to fuzzy representations of speech sounds	You're working on *input* (fuzzy representations of a sound) to change *production*

6.2.2 Target: traditional, functional and non-traditional

To direct change in a child's speech, SSD intervention exposed them to specific speech sound(s) and / or other linguistic units (Targets). Target selection did not fall neatly into the traditional / non-traditional dichotomy of the Approach, and three types were in use: traditional, functional, and non-traditional (Table 6-5). They were not mutually exclusive, and were used to different degrees by different participants for different clients.

Table 6-5: Targets and linked Approaches

Target selection	Linked non-traditional Approaches
(Variation on) traditional	Cycles, Perception
Functional	Core Vocabulary
Non-traditional	Complexity, Multiple Oppositions, Stimulability

Traditional Targets had a straightforward correspondence with an observed deficit and the anticipated change in a child's speech. Participants wanted intervention to place the least possible cognitive and linguistic demands on the child. Target decisions therefore incorporated age-related patterns of expected development, ideas about the number of Targets the child could cope with, and what the child could do most easily (e.g. sounds and word positions where they were already stimulable). To a lesser extent, Target decisions were influenced by linguistic ideas about what might make the biggest or quickest difference.

Functional Targets gave priority to participation in everyday activities and settings. They included a specific sound arising in any word as part of a daily routine, being intelligible within a context, and learning to say words of special interest such as superhero names. AAC (alternative and augmentative communication) could also help a child communicate in situations of extra demand, such as doing a talk in school. Although functional Targets were familiar through work with other client groups, they were not traditional for SSD. Participants reasoned they could be intrinsically motivating, enable effective communication, place fewer demands on families, and promote friendships.

Non-traditional Targets were distinguished by a linguistic rationale for doing Target selection differently. This hinged on accepting that 'implicational

relationships' between sounds exist: in other words, that having particular sounds in the system and structure implies certain other sounds must also be present. Participants referred to implicational relationships using terms including 'distance metrics', the 'sonority sequencing principle' and 'consonant / fricative clusters'. For [Fran] the point was to be "two steps AHEAD of the game" and "PUSH their system" for faster progress through downwards linguistic or systemic generalisation. Non-traditional Targets included sounds a child was not stimulable for, later developing sounds, multiple sounds, and sounds that had very different linguistic features. Target selection could also extend beyond speech sounds to take into account the most facilitative linguistic contexts, including word class and length, and non-words. This meant [Paula] was:

> TRYING to be more.. specific and more evidence based even at the level of 'Why have we targeted.. THAT particular.. <fr> word as oppos- instead of THAT <fr> word?

6.2.3 Focus: traditional, non-traditional and non-mainstream

Focus is my label to denote what a child was asked to *do* in an intervention task so the selected Approach and Targets could work their effect. It relates to at least one point on the speech chain continuum from what the child was hearing through to what they were saying. It encompasses concepts such as auditory and production, and input, perception, identification, discrimination, internal representation, programming, output.

Although Focus was challenging to define, it was important to account for it. A therapist could use the same Approach and Targets, but differentiate intervention by its Focus. Focus could be inherent in – or implied by – an intervention. Any intervention could involve more than one Focus at a time, and the Focus might shift with progress or fluctuation (e.g. of hearing).

The traditional Focus of SSD intervention followed a process of auditory discrimination and production. The seeds for disrupting this had been sown by the psycholinguistic Approach; implementation of any intervention was nonetheless confounded when the suggested Focus challenged ideas about the order in which things ought to be done; what was separable and

inseparable; what would ultimately make a difference; and what the child could or could not already do.

There was little evidence in this sample of engagement with non-mainstream interventions[24]. Where it did occur, these were not used as standalone interventions, but as a task Focus to augment and complement mainstream (traditional and / or non-traditional) interventions. One participant had recently introduced oro-motor tasks for children with severe SSD, another could refer children for a programme of listening to sound wave CDs, and another supported children to identify personal mental pictures of what they wanted to change.

There was also little mention of instrumental interventions, which Focus on visual biofeedback, other than to argue for more equitable access for children with persistent SSD.

6.2.4 Meta-language: specified, personal and unspecified

Historically, a child's understanding of SSD and intervention was assumed. Colour Coding and Metaphon introduced the idea of using concepts to group and contrast speech sounds by linguistic feature. Participants did not use the term Meta-language, and had a variety of opinions on selection criteria and the value of time spent teaching this. They did however refer to the challenge of having an effective shared way of talking with children, parents and therapy partners about speech sounds, SSD and intervention, and tried to make these abstract concepts more concrete and memorable.

For some, a personalised Meta-language was most efficient and effective. [Aileen] and [Isobel] encouraged children to come up with their own labels, with [Isobel] extending the multi-sensory element to include visual, movement, olfactory or tactile dimensions.

Other than Stimulability (which linked sounds to characters), non-traditional named interventions did not come with a specified meta-language. Participants

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[24] To preserve anonymity the interventions and participants are not named. Two of the three related to NHS settings.

therefore drew on a specified Meta-language to keep children, parents and therapy partners on board.

6.3 Logistical layer of intervention

The logistical layer recognises intervention has to be provided somewhere, by someone, in a quantity. It did not lend itself to the same kind of typology as the theoretical layer. Instead, there were conventional and unconventional options for Place, Format and Dosage, with the range locally determined.

6.3.1 Place: locally conventional and unconventional

Historically, community speech and language therapy was delivered one-to-one in a clinic or school. These locally conventional Places had persisted for SSD intervention, with some school-based models now run like a clinic (i.e. with pre-arranged appointments and parents attending). NHS participants worked within or across these models, and some had experienced a shift from one to another. Clients' homes were an unconventional Place for children with SSD, but the default for the private practitioners. Perceived advantages and limitations from participants' perspectives are in Table 6-6.

Table 6-6: Advantages and limitations of Place

Perceived advantages	Perceived limitations
Clinic	
Number of sessions has to be planned, negotiated and agreed with parents. Requires therapist to explain rationale for intervention and homework to parents, so therapist thinks more about the rationale. Clinic space is peaceful. Parents may get support through meeting other parents in waiting area. Meetings with teachers are pre-arranged. Better outcomes for children. Opportunities for group Format.	Getting clinic space is challenging. Spending focused time with parents is intense. Some clinic rooms are small and unsuitable for families. Have to be sensitive to people who can't travel. Can be seen as a luxury. School potentially dealing with several therapists
Peripatetic in schools	
Some ability to vary who gets seen on given day and for how long. Being around classrooms offers opportunities for liaison with teachers. Not reliant on parents to bring children. Good relationships with schools make it easier to find therapy partners. Fits with principles of Early Years Collaborative. Opportunities for group Format in larger schools.	Limited contact with parents. Pressure to see more children and spend less time with each. Difficulty getting suitable space for one-to-one. Noise levels. What's going on in school affects attendance. Intervention has to be simplified. Can disadvantage children with severe SSD who need time.
Peripatetic clinic service in schools	
Service more accessible, especially for rural / dispersed / disadvantaged population. Parent / carer expected to come in for some / most / all appointments. May increase opportunities for teacher liaison.	Can be inequitable when one school has higher caseload / waiting list than another. Inflexible for Dosage. Group Format less possible.
Child's home	
Parental involvement standard. Wider family can be involved, e.g. grandparents. Child in own environment with therapist as visitor. Parents more honest about thoughts and feelings. Therapist sees impact of relationships and context on behaviour, so can offer more holistic and relevant input. Therapist can customise strategies to home set-up and child's interests. Session length can be varied depending on need, e.g. longer in earlier stages. Therapist becomes more realistic about what parents can do.	Not possible in an NHS role?

6.3.2 Format: conventional and unconventional

Format relates to how people are involved in an intervention. Historically, specialist SSD intervention was a child / therapist dyad. Conventional Format had evolved to encompass people (particularly parents) as therapy partners, delegation to speech and language therapy assistants, and groups of children. A parent group was considered unconventional.

'Therapy partner' denoted a designated person – usually but not always a parent – who agreed to support the child's intervention. Motivations for involving parents or a proxy were *moral* (they were the child's parents but, as [Jenna] said, "AREN'T walking about with this.. knowledge..."), *practical* (they wanted to know how to help their child and had everyday opportunities) and *instrumental* (they offered an additional or alternative way to deliver intervention). The spectrum of therapy partner involvement was broad, from sending activities for home practice to making attendance a condition of intervention. The Format of therapy partner involvement during Sessions also varied widely, from observation of some or all, to full participation.

Not all participants had access to speech and language therapy assistants to support intervention delivery (Format). Those who did valued them highly.

Groups took considerable administrative work. Experiences of the value and purpose of groups, and of their acceptability to parents, varied widely. Participants most committed to groups emphasised a social rationale, good attendance and the existence of research evidence. Those most sceptical emphasised the need to individualise SSD intervention and a poor 'track record' with group attendance, gelling and effectiveness. As a consequence, each found their Format more efficient. Parent groups were conventional with other client groups, but unconventional for SSD.

6.3.3 Dosage: conventional and unconventional

Dosage refers to the idea that quantity of intervention can make a difference. It relates to how much, how often, how repetitively, how regularly, how distributed, or for how long an intervention is likely to be needed to be effective, whilst recognising a child's actual response varies for many reasons.

Conventional Dosage was characterised as once a week direct intervention for around 30 minutes. Although what [Rhona] termed the "gravitational PULL" of this had proved "surprisingly" resilient, it was being challenged from two angles: was it effective, and was it sustainable?

The most rigid constraints arose when therapists covered a variety of clinics and schools to increase access for dispersed or disadvantaged communities, and when a formal or informal cap was placed on length or number of sessions. While recruitment and staffing challenges and part-time working made it less possible, some participants were challenging convention by proactively becoming more flexible with Dosage.

6.4 Processual layer of intervention

The processual layer is about supporting a child through intervention so they can change their (speech) behaviour. The Scaffold can be more or less congruent with how the therapist sees their role with children, while the Session plan can be more or less routine.

6.4.1 Scaffold: congruent and incongruent

The Scaffold element recognises that behavioural techniques support progress with intervention. Two main strategy types (support; feedback) were implemented in four ways (power shift; non-directive; facilitative; directive) (Table 6-7).

Table 6-7: Scaffold

	Support strategies	**Feedback strategies**
Power shift	'Playing around' with sounds together Being explicit with child Child draws the word Giving child (illusion of) control	Deliberate mistakes with self-correction Self-monitoring scales
Non-directive	Modelling	Recasting
Facilitative	(Multi-sensory) Cueing Simplifying Making visual	Barrier games Feigned confusion Charting progress
Directive	Eliciting sounds Drilling / repetitive practice	Praise / evaluation Rewards

The Scaffold element is key to understanding how participants saw themselves, their clients and intervention, and the energy they invested in their work. Participants were flexible with Scaffold depending on the child, but they also had preferences.

Scaffold could be the difference that made the difference for particular children. For one of [Jayne]'s clients, a power shift ("letting her be the leader" in games where "I would be.. the em.. person that she was telling what to do") led to "overnight" system-wide generalisation of <s> after working on it "for months". Non-directive Scaffolds were uncontroversial, and popular for enabling parents to support their child's speech. Facilitative Scaffolds built children's confidence and were core to practice. Participants saw the need for directive Scaffolds, but also expressed ambivalence which had implications for practice change (6.6.3).

6.4.2 Session: routine and non-routine

A Session orders and structures elements of intervention to meet the needs of a child in an allotted timeframe. Session was much less noticeable than other intervention elements, suggesting its relevance to implementation risks being underestimated.

As both were at the processual layer of intervention, Session and Scaffold interacted. For example, to help a child cope, [Isobel] made the structured routine of a Session more visual and gave him control (power shift) over the order in which the activities were done.

6.5 Observable layer of intervention

Therapists' SSD intervention work is not easily observable in a Session. An exception is the Material used.

6.5.1 Material: adaptable, individual and personal

Material comprises what is used to make intervention interesting and fun for children, parents and therapists. It can be generic or bespoke, home-made or commercially available, and low or high tech. For SSD, it needs to reflect local vocabulary and vowels.

Material was not trivial; it held traditional intervention in place, and compounded the challenge of practice change. Some interventions lent themselves to Material which could be used or easily adapted for a range of children. Others had a linguistic rationale that required very individual Material, and software which could have assisted was American. Material which was personal to a child and / or their interests could be more motivating.

6.6 Intervention change: from traditional to non-traditional

With the benefit of the SSD intervention change model, it is possible to imagine the implications of different scenarios. Take the example where a therapist provides traditional intervention, most usually comprising a traditional Approach, with traditional Targets, a traditional Focus, a specified Meta-language, a locally conventional Place, conventional Format and Dosage, a congruent Scaffold, a routine Session and adaptable Material. How then does this therapist avoid being overwhelmed when a non-traditional intervention is suggested which - after considerable effort to make sense of what it actually involves doing - requires a non-traditional Approach, non-traditional Targets, a non-traditional Focus, an unspecified Meta-language, a locally unconventional Place, conventional Format but unconventional Dosage, an incongruent Scaffold, a non-routine session and individual Material? And all this without taking into account what it would also take in other aspects of the practice context.

Before starting fieldwork, I had assumed non-traditional interventions would be challenging to implement. As [Vivienne] observed:

> you know, you kind of have... session plans in your HEAD for things, even if you never write them down, and if all of the way you're used to doing.. has to CHANGE, I think that's a much bigger ASK to change your practice.. whereas if you can just 'tweak' something.. for a good theoretical reason... that's EASY to do (pause)

What I had not anticipated was the extent to which traditional intervention was or had been entrenched. I was also perplexed by what 'traditional' meant, as I had not realised a Sound-by-Sound Approach would have continued to underpin thinking, even in more recently qualified therapists. Such

expectations, surprises and confusion were essential to casing what was traditional and non-traditional. In this section, I will draw out key moments from participants' talk in relation to the model of SSD intervention change to illustrate what it was like to move from one to the other.

6.6.1 The hold of traditional intervention

Clues that traditional intervention was taken for granted came as participants repeatedly referred to SSD as 'bread and butter'. [Carolyn] felt it hadn't "hit the RADAR" in the same way as other client groups:

> 'well that's your bread and butter' it's sort of an ASSUMPTION that kind of somehow.. you KNOW everything there is to know, that everything is- that there IS to know is probably contained within that 'Working with Phonology' book?

For [Hannah], SSD as "bread and butter" meant she was less likely to notice that "I tend to have been.. doing it the same way for a LONG TIME", particularly as this was usually "quite effective":

> it's more the bits that I tend to become a bit unstuck are when that's not-.. you know, you've done, you've done what you always tend to DO.. and actually it's not, it's not working and the change isn't happening.

[Erin] only realised a Session *could* change when she implemented non-traditional interventions:

> you DO still do the same THINGS... but you DON'T have this same same same same same.. em SESSION plan... that you go ALONG with, you have to think... for this this child, right, I need to do THAT, and actually they're really STRUGGLING with that, so I might do a wee bit MORE listening work today... than I did last week or.. whereas BEFORE.. I-I.. was DEFINITELY just.. 'oh that's phonology, oh right they're coming in', I-I would just do the same thing!

Therapists had learnt to assume lack of progress was not about their Approach. Before [Wendy] was introduced to non-traditional interventions she was "working with FAMILIES" (Format) and doing other "really kinda POSITIVE things". While "slightly dissatisfied" when progress took a lot of time or effort:

> I didn't think of that as being an ISSUE for.. [[mm]] from MY perspective?.. it was that the parents hadn't done the HOMEWORK or.. something ELSE

had kind of got in the way versus actually maybe.. we're not.. DOING the right thing?

Participants' word choices also suggested they faced entrenched assumptions about how things should be done. With Dosage, [Isla] hadn't "EVER seen anybody for a block... longer than about.. twelve weeks" because that was "how we're sort of programmed to BE". To allow a non-traditional Focus, participants had to move away from what [Elizabeth] termed the "psychological reality" underpinning the traditional process:

> there's certain things I DO.. so.. that I.. you know.. certain kind of auditory discrimination.. activities or so on.. where... just me personally being a bit.. kind of over.. (laughs) thinking it.. I-I kind of think well (pause) I don't KNOW that there's a link between them having to hear the difference- I feel like I'm a HEATHEN now- but they, you know, okay, they might not be able to discriminate that sound.. but in my PERSONAL experience over the past couple of years.. they can.. be able to discriminate the sound.. and it makes no difference to the production. They can.. they can NOT discriminate the sound.. but they-they can learn to say the sound just FINE..

A culture of complacency was not the only reason traditional intervention was entrenched, as the clinical reality of children who could not produce particular speech sounds pulled therapists towards it. [Sally] frequently passed on sound elicitation techniques learnt years ago on placement, and [Emily], [Louise] and [Aileen] valued new Scaffold "tricks", such as an "angry cat face" or the Darth Vader technique for velars, tips to address active nasal fricatives, and getting a <ch> from <t>+<y>.

Traditional intervention also exerted a hold through the easy availability of Materials such as photocopiable Black Sheep Press sound packs. Banks of Colour Coding and Minimal Pair resources had been built up locally over the years, and [Emily] had "Metaphony" resources from university that enabled her to "do lots of general back and front stuff". Reflecting on increased priority to Phonological Awareness, [Myra] acknowledged:

> I suppose to be FAIR, too.. PART of the reason it's because we have nice MATERIALS (pause) [[yeah]] you know, that are.. (overlapping) good to USE with the kids

As [Fran] explained, these banks of Material also enabled therapists to do more therapy in the available time:

> Cos before I've got my wee folder, my <k> folder, where I had my front-and-back, my t-and-k, my snaps, my games, I could just.. GRAB that, whereas actually you're having to do MULTIPLE oppositions and have CERTAIN words and sounds.. that there's NO WAY: that you just would GRAB.. d'you know?

6.6.2 The promise of non-traditional interventions

To deploy an intervention, participants had to know it existed. Those who now used non-traditional interventions were perplexed that none were new to the literature. For [Sophie] this was "almost EMBARRASSING". They also had to perceive a benefit. The non-traditional interventions were aimed at children with severe difficulties, the sort who could still leave [Sonia] "blotchy necked", or [Megan] "a wee bit at the end of my tether as w-what do I DO here?" Some mapped on to particular SSD patterns or new diagnostic categories, meaning [Isla] could "get there quicker" by missing out routine steps and only doing what was necessary for that child to progress.

Understanding the Approach took considerable time and intellectual effort, even when someone was 'a reader' and proactive in tracking down sources, and eventual understanding was frequently experienced as a 'lightbulb moment'. However, mixed success meant it was difficult for participants to judge whether the investment in understanding and implementation was worth sustaining. A number realised they had made mistakes, but the child had improved anyway. Others had defaulted to usual practice supplemented by experimentation. Some were employing non-traditional interventions both as intended and strategically according to a particular child's circumstances. Others, like [Paula], were brimming with excitement and thinking critically about what more they could offer:

> we're seeing some really.. QUICK... changes.. em.. and it's almost like we're managing.. for SOME children we're managing to hit.. the-the RIGHT target.. FIRST TIME.. [[mhm]] and for other children it's NOT but I think we've now got.. I'VE certainly now got more confidence in being able to say, 'right, so WHY has that not worked for that child when it DID work for THAT child, WHAT'S the difference, WHERE is it breaking down, and what do I need to TRY.. different' whereas I think previously I'd have just gone, 'och, you know, they're not READY to work on <s> clusters, let's

try... something else' and just randomly picked something else that they.. needed work on [[mm]].

6.6.3 Trying to use non-traditional interventions

Even when participants invested in understanding non-traditional interventions and, like [Erin], were "really excited" to try them out, the pull of traditional intervention was strong. Sessions "just felt SO ALIEN" and "really BIZARRE" meaning [Erin] had to "FORCE myself to just.. go out of my COMFORT zone (pause) em oh yeah that was really... that was really difficult.."

The relational nature of speech and language therapy was crucial to explaining this experience. Participants liked to enable children to experience success. Using linguistically complex Targets on the promise of overall faster progress, they struggled with children not succeeding for longer than usual. [Hazel] "wouldn't have BLINKED" about consolidation breaks with traditional intervention, but needed a colleague's reassurance when a Complexity Approach prompted progress in the child's awareness and knowledge of speech sounds but no discernible difference in his impairment:

> And I sent him out my room and my heart sank and I felt a COMPLETE FAILURE? And he came back in six weeks and he'd, I can't TELL you how much he'd moved on? It was like a MIRACLE. (laughing)

[Diane] was perplexed by a Multiple Oppositions instructional DVD:

> she's TALKING about some Metaphon principles and she might say this, 'remember this is a long sound' or 'this is the QUIET sound'.. but there's nothing about where you... what a- ARTICULATION's going on... which is.. quite STRANGE [[mhm]] because the CHILD is gonna say.. the same word five TIMES (pause) for that sound, d'you know what I mean? so... I find that quite STRANGE cos she wasn't REALLY... TRYING to get them to change the way they were saying it?...

[Jackie] agreed it was "really HARD sitting there" and "listening to a child.. not ACHIEVING" for longer, especially if the child was aware. [Erin] acknowledged this "panic" and the need to Scaffold:

> if you're working on an EMPTY SET, you know and you're choosing two.. eh sounds that AREN'T stimulable and that come LATER on in development and you're using all your implicational laws and things like that... and they, they absolutely can't DO them.. em.. I think it's just... YOU thinking to yourself 'right well... well they can't DO it just now but.. I need...

there's still ways to give positive PRAISE... em and for them to be REWARDED in the session... even if they're not getting exactly... what we need them to GET..' and I-I definitely think it's more about the THERAPIST than the CHILD..

However, Scaffold was often incongruent when non-traditional interventions involved drilling. [Niamh] described the "repetitive" Multiple Oppositions:

it's quite a.. DRILLING kind [[IS it?]] of process really.. [[right]] yeah.. it ca-.. yeah yeah.. and so they would.. contrast it so their with their ERROR patterns so.. if it was.. <dot> everything went to <d> so <dot> you would.. again if you were targeting <sw>.. <dot> and <swat>... you would have.. kind of and they would have to say dot-swat-dot-swat-dot-swat

[Diane] found this "monotonous" and "dry". If [Heather] made it exciting with a reward, it lengthened the time, making it difficult to achieve the required Dosage, even within a longer Session. [Elizabeth] was also concerned drilling risked placing the child in a passive rather than active role in therapy.

Therapists could however be pleasantly surprised by children's responses to non-traditional interventions. [Isla] used Core Vocabulary, where the Targets were not particular sounds but consistent best production (output Focus) of any whole word from a set meaningful to that child:

we worked on 'waterslide' because she was going.. away to [names a family holiday village].. and she wanted to go on a waterslide, so I.. SHE picks the words, we've got a BIG list that we- that MUM adds to, and that NURSERY adds to, if there are things that SHE wants to talk about that she's finding really difficult to say, worked on 'karate' before.. things that you would think from a THERAPIST's point of view ((puts on fed up voice)) 'oh! that's gonna be really hard! She's not gonna manage that cos it's got a <k> or it's got too many syllables'.. she's SO MOTIVATED to get.. those words out

If non-traditional interventions were strange for therapists, they could be even more difficult to explain to parents (Meta-Language). Based in schools, [Fran] struggled with homework:

in the PAST I've been able to take a wee thing to a parent, 'we're working on front and BACK, can you do this-this-this GOOD' but lots of these words are like 'Bub'? you know, which is a wee monster? Em.. and 'Bush' ((rhymes with rush)) which is another wee clown.. you know, all these wee things that I'm making NONSENSE words to relate, to the-the words that I'm TARGETING.. but there's no way I can send that home to a parent,

cos they're like 'what the hell is this Fran's sending us home?'
[[(laughing)]]

[Louise] found parents could understand when she explained the child's *SSD* but this was not sufficient for them to understand the *intervention*. Talking about a phoneme collapse could lead to "oh YEAH!.. They're saying a <d>.. for all these CONSONANTS" because it was "quite CONCRETE". However, it was much more "CHALLENGING" to explain why a Multiple Oppositions Approach would address it:

> So it's ultimately down to the, you know it's down to your SKILLS.. in terms of how you're able to PRESENT that and SHOW the parents and.. or WHOEVER is the therapy partner.. in terms of how they're gonna actually then.. support the CHILD with that

Non-traditional interventions also brought logistical challenges (see Place in 6.7.1). With one exception (fricative cluster Target), they did not lend themselves to a group Format. They were also more challenging for speech and language therapy assistants, so depended on them being skilled, experienced and well prepared.

Guidance around Dosage was variable and not always seen as credible. [Heather] noted Stimulability was "quite… prescriptive", almost like having "a wee MANUAL", while others were left more "up to YOU". [Sophie] preferred to "dabble" in Dosage for children with severe SSD to see if this produced "BIGGER gains". [Maureen] followed Dosage protocols to provide Stimulability and Core Vocabulary but "when things HAVEN'T worked" re-read articles and discovered they were providing the total but not in the recommended distribution. Inherent uncertainty around Dosage made flexibility essential. [Paula] found discussion with parents important in "getting away" from the idea that "more is always better", while [Niamh] noted:

> there's no magic FORMULA. And there never WAS. It's ju- it's not THAT different to.. [[mm]] traditional therapy in the sense of some children... DO have ten weeks of multiple oppositions and you put them on consolidation and.. and others have twenty! [[yes]] (laughs) cos that's what they NEED! To GET it.

6.7 Intervention change: implications of the logistical layer

Imagine now a second scenario, where a locally unconventional Place, Format or Dosage is introduced, perhaps as a Service response to Caseload pressures. Having considered the SSD intervention change model, is it possible that this could have no implications for other layers of intervention?

Rather than existing outside the intervention, the consequences of the logistical layer for other elements and the whole intervention in this study suggest it is integral to it. I was struck by how logistical changes and lack of agency had a personal effect on how participants felt about their work and what they could or could not achieve. In this section I will illustrate this with a variety of examples.

6.7.1 Changing Place

The almost defensive tone of discussion about the best Place for intervention betrayed the long-running debate in the profession. From NHS participants, there was a persistent message that a clinic was the best *default* for children with severe SSD whilst maintaining school as an option. Reasons included the opportunity for depth (theoretical layer), working more effectively with parents to increase Dosage (logistical layer) and access to Material. However, many lacked agency to change to clinics. Even when they had agency and there was a local need, negotiating suitable clinic accommodation could take years.

[Jess] now tried to see "ALL PHONOLOGY kids" in a clinic "WITH a parent". Working in a deprived area, where schools were the easiest Place to see a child regularly whether or not parents attended, this was "a MASSIVE change". [Maureen] was surprised by the benefits. In schools, "you just kinda went to the classroom and took them out and.. did what you did.. and if you were lucky you got to liaise with the teachers", but in a clinic:

> with a.. parent sitting in front of you as well, when you're.. asking them to commit to therapy with their child it.. almost felt like you WANTED to have more of a rationale for what you were doing and why you were doing it and.. for some parents it's about taking time off work and actually.. you know making sure that.. they were understanding the VALUE and the importance of what they were doing

Where clinic options had been removed, [Kate] felt a loss of the "much more CALMING environment" and a lack of control as "i-it's HARDER to kind of engage and work with parents and.. with staff. Because EVERYBODY'S pushed".

Participants in private practice found unexpected benefits of seeing children in their own home. [Aileen] did "a lot more ADAPTING to.. the HOME.. sort of environment" as she could "see how the family works, and I can see.. how they 'fit in'.. their practice (laughs)". [Isobel] could "look at how their house for example is STRUCTURED" and help them think about how they could support intervention, by using toy figures in the bath to practise Stimulability, or be more motivated by their own Material such as juggling and magic.

6.7.2 Changing Format

Format changes drew attention to the distribution of work. [Aileen] had come to realise how much help parents needed "to DO that practice and to know HOW to do that practice". [Jenna] also tried to be sensitive:

> parents.. have a lot of things that they're... that they're trying to juggle in their lives in terms of.. housing and just, just safety, security, you know, so it's whether THEY'RE in the place, you know we want to build up THEIR confidence and.. they ARE really trying? and it's GREAT that they're coming?

The line between therapy partners as distributed expertise or as a transfer of responsibility was often hazy, as was the line between running groups set up primarily to benefit clients or to increase throughput.

Parent groups were conventional with other client groups, but unconventional for SSD. The two examples of groups introduced with the aim of equipping parents to support their child's speech were logistically similar. However, using interview and documentary data to identify the most salient feature of each intervention element (Table 6-8), fundamental differences in how these interventions were expected to work became clear. This suggests risk to the theoretical layer of intervention if parent group Formats are viewed only as a logistical change.

Table 6-8: Comparing parent group Format

	Intervention 1	Intervention 2
Format	Parent group	Parent group
Place	Clinic	Clinic
Dosage	1 x 2 hour session, 3 month review	2 x 1½ hour sessions following assessment
Approach	Sound-by-Sound / contrastive (Minimal Pair)	Phonological Awareness
Target selection	Single sound	Functional
Focus	Production	Input
Meta-language	? Implicit	? Explicit
Scaffold	Facilitative	Non-directive
Session	Detailed	Detailed
Material	Supported by Black Sheep Press single sound pack	Within personalised booklet

6.7.3 Changing Dosage

Given the "evidence base", [Nicole] was "TRYING.. where possible to give kids.. MORE INTENSIVE therapy…". [Grace] used time previously spent one-to-one with "low tariff" children to increase intensity for those with severe SSD. When she judged a child was "ready" [Morven] saw them twice a week herself, worked with assistants, and included them in groups:

> in the PAST.. I might have been trying to ENSURE that a child was getting regular consistent input.. through another agency.. like the parent.. and I might go in once a week.. but I found that that.. was PERCEIVED.. by everyone else as.. the therapist is doing therapy once a week. That's IT. Nobody needs to DO anything else. .hhh hhh.. hhh So I felt I needed to be there to be.. DEMONSTRATING therapy.. GUIDING therapy... and having that regular contact.. MYSELF.. I think more readily ENSURED.. that something was happening on the days I WASN'T there (pause) and I found that that was effecting change more READILY (long pause)

Participants who lacked agency in relation to Dosage were frustrated that research argued for increased and unrealistic quantities. Rather than a "super luxury service", [Isla] provided "the best we can do (laughs)":

> I try.. quite hard.. ((puts on voice suggesting she is cringing)) not to think about.. too much? because if you DID think about (pause) we're not effective- and actually.. IN PRACTICE.. I KNOW that WE ARE effective, you know.. I-I can SEE that I'm making.. a difference, but if you- I can see why people.. choose NOT to read research, because they (laughing) find it too depressing.

Dosage decisions had consequences for specialist SSD intervention, as shown in the ethnodramatic monologues (Figure 6-3).

Figure 6-3: Dosage monologues

One change when I came back to work was being expected to give weekly therapy in blocks of 6 to 8 weeks, followed by a break. I think it came about in an effort to manage numbers, but it actually fits well with school terms and people's busy lives. And I like the way it gives you a natural chance to reflect on whether what you're doing is working. If I'm honest, it's also a relief not to have to see a child week after week forever, and it helps you transfer some of the load to therapy partners. It's a shame when you feel a child would benefit from more, or it would be better to press on than have a break. But there's not much I can do about it because of the way my caseload is, and the number of clinics and schools I cover. You hear about research where they've spent two hours a week for three months with spectacular results – but how's that relevant to us? WE have to be equitable and, with our numbers, even once a week's becoming a luxury – most children I see, it's less often than that.

———————————————————

I think we've always known children with really meaty speech difficulties would benefit from intensive therapy – I saw it with the wee boy I got into a Language Unit. He came on much quicker, but they weren't doing anything different with him, there was just more OF it. After all, you can change the way you present things, or the conversations you have, but fundamentally the THERAPY doesn't change, does it? The great thing is we were given time to stop and really think about what we're doing with our service. This means we've been able to make a space where we CAN offer therapy more than once a week if we think it's necessary. That's great for the kids with more severe problems. But you know what's interesting? When we do it, EVERYONE seems to get on board. I wonder if something about intensity makes people realise it's not just the therapist's responsibility to do something?

———————————————————

Ah, you mean dosage! We're all being a bit more flexible with dosage here. The new speech sound approaches we've all learnt about come with different dosage recommendations: this could be the number of 'hits' in a session, or the length of a session, or the frequency and number of sessions in a block. And, because we're now aiming for generalisation from the start, we need to build in time for consolidation, and know when it's okay to discharge. It's been a huge change to our way of working, but we've seen some amazing results with really severe children. I'd say you can't plan an episode of care without giving dosage some thought - but it's tricky to be flexible, even though we keep our caseloads small, and use assistants and parents as well. And, you know, you don't always need the dosage the books say. So we have to be sure it makes a difference – that's why gathering our local evidence is so important.

The first narrative, driven by a desire for service equity, risked losing depth and diversity in the theoretical layer. The second, where more was given to some, also concentrated effort and distributed responsibility. The third, where the aim was to make the most difference in least time, increased therapists' agency to vary Dosage and the theoretical layer of intervention.

6.8 From Intervention to Candidacy

The inductively derived model of SSD intervention change makes it possible to map SSD interventions and compare their layers and elements. It makes visible why implementing different SSD interventions may be more or less challenging but cannot ever be a simple matter, even if a therapist and service perceive a need.

However, Intervention does not exist in a vacuum but as an interdependent part of a wider practice context for change. The theoretical layer of Intervention is closely related to the Candidacy dimension of SSD specialist knowledge, while the processual layer parallels the Candidacy dimension of therapeutic sensibility. The logistical layer is clearly related to the Service aspect, and the observable layer has a particular relationship with the Caseload aspect, which influences what Material is most practical.

To receive intervention, children had to be considered a candidate for it. The next chapter will therefore explore the Candidacy aspect of the practice context.

7   Candidacy aspect of the practice context

7.1   What Candidacy is, and why depth matters

Candidacy is a social science construct based on critical analysis of evidence about the work of accessing healthcare, including how service provision and professional adjudication make this more or less possible for different people (Dixon Woods et al. 2006). To receive speech and language therapy intervention at the specialist level, a child had to be considered a suitable candidate. This was not a straightforward one-off decision, but a complex ongoing judgement around starting, continuing with and ending therapy. Candidacy seemed an appropriate concept to apply as this aspect of the practice context was awash with political questions (who has the right to intervention?) and ethical dilemmas (what is the right thing to do?)

Historically, speech and language therapists have always been autonomous practitioners. Candidacy judgements were increasingly constrained by resources, but were still ultimately made by therapists. However, compared with past practice, participants took many more perspectives and factors into account, and drew on an array of decision-making tools.

As with other aspects of the practice context, Candidacy was dynamic. However, unlike other aspects, across the sample it was moving in the same direction. Candidacy had two necessary dimensions, each with three underpinning concepts (Figure 7-1); the difference that made a difference for trajectories of practice change was depth of application.

Figure 7-1: Candidacy dimensions and concepts
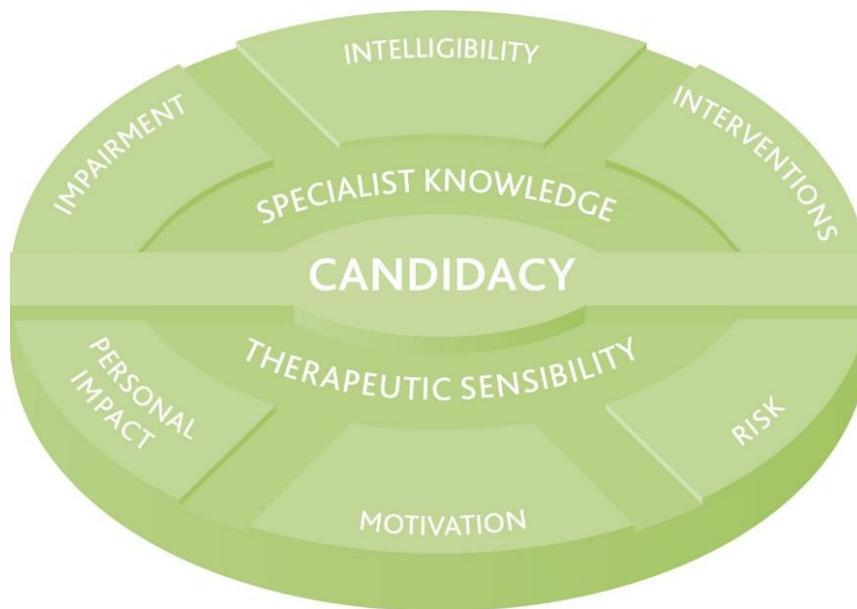
7.1.1 Candidacy dimensions and concepts

The first Candidacy dimension was specialist SSD knowledge. It referred to judgements about the child's impairment, intelligibility, and suitable interventions. The second Candidacy dimension, therapeutic sensibility, referred to judgements around personal and family impact, motivation for therapy, and risk. Specialist knowledge was specific to SSD, while a therapeutic sensibility was relevant to all clients as it involved taking into account what an impairment meant for a particular child and family, and what they would be bringing to the therapy table.

Contributions suggested that impairment had always underpinned Candidacy decisions, that intelligibility, impact, motivation and risk were increasingly taken into account, and that some participants had started to integrate knowledge of suitable interventions with Candidacy judgements. Table 7-1 lists the working definition of concepts in each Candidacy dimension. These are presented as the sorts of questions therapists asked themselves or others in relation to each concept to establish the child's Candidacy, and the variety of decision-making tools they used to support this process. As analysis was based on participants' description, and this may or may not correspond with how these tools were intended to be interpreted or used, they are not specifically cross-referenced with the research literature but are signposted in Appendix 9.

Table 7-1: Working definitions of SSD Candidacy concepts

Concepts	Questions	Decision-making tools
SPECIALIST SSD KNOWLEDGE		
Impairment	How severe is it? How entrenched is it? How persistent is it? How disordered is it? How consistent is it?	Assessments PCC / PVC[25] Severity levels Care Aims / Risk Matrix TOMS[26]
Intelligibility	How intelligible is the child? How intelligible is the child to different people? How intelligible is the child in different contexts?	Informal rating scales Intelligibility in Context Scale
Interventions	What intervention approaches would most help this child at this time? What do I need to do to provide the child with the most appropriate intervention approach?	Knowledge brokers What Works Flowcharts / models Textbooks Papers Knowledge Network
THERAPEUTIC SENSIBILITY		
Personal impact	How much does the SSD bother, frustrate, upset or affect the child's wellbeing? How aware is the child of the SSD? How much does the SSD bother the parent? Relative to other things in the child and family's life, how much does this matter right now, and is it a priority?	Care Aims Patient Story Triage SHANARRI[27] / Wellbeing Web Talking Mats TOMS Informal rating scales SPAA-C [28]
Motivation	How willing is child to engage in therapy? How willing is parent to engage in therapy? How willing is nursery / school to support therapy? Is there a Therapy Partner?	Care Aims / Risk Matrix Triage Asset based / solution focused approaches
Risk	What is already being done to support the child? How is the child already improving? Who is best placed to support this child right now? What will happen without intervention at this point?	Care Aims / Risk Matrix TOMS Asset based / solution focused approaches

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[25] Percentage Consonants Correct / Percentage Vowels Correct
[26] Therapy Outcome Measures
[27] Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included Indicators
[28] Speech Participation and Activity of Children Scale

7.1.2 Why impairment no longer implied Candidacy

While a therapeutic sensibility has always been integral to the work of speech and language therapy, [Rhona] reflected that "on the whole" we were "PROGRAMMED through our training and clinical experience.." to see Candidacy in terms of impairment:

> I think before we used to TAKE it as our problem. And then get.. very frustrated when we couldn't SOLVE it. But it's NOT my problem. Em.. so how can I work.. how could YOU work.. to.. you know, bring your skills, bring your experience, bring your knowledge.. to that situation ALONG WITH.. THEIR experience, THEIR knowledge, THEIR perception. To CHANGE that situation. And it may not be the change YOU were anticipating

Potential candidates were now viewed not just as individuals, but as part of families and other units key to supporting their communication development. An identified impairment was still a necessary but no longer sufficient condition for Candidacy.

[Vivienne]'s former practice was "Has this child got a speech problem, well I'd better be involved then", and [Erin] accepted every referral "cos that sound's HARD for them, and I can DO something about that". Now, instead of a duty to be involved if a child had an impairment, therapists had to consider whether - in spite of an impairment - this was the right thing to do.

This shift in thinking had been shaped by a variety of decision-making tools developed for a range of client groups, in particular Care Aims and Therapy Outcome Measures (TOMS) (both originating within speech and language therapy), and more recent initiatives associated with Scottish Government policy[29], such as Triage[30] and a focus on wellbeing. Table 7-2 shows the key assumptions which Care Aims, TOMS and Triage had brought to participants' Candidacy judgements.

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[29] Ready To Act – A transformational plan for children and young people, their parents, carers and families who require support from allied health professionals (AHPs)
[30] Now superseded by Request for Assistance

Table 7-2: Assumptions of Candidacy decision-making tools

Tool	Key assumptions
Care Aims	1. Specialist intervention only justified if the impairment is having an impact on the child, and if there is a risk from not intervening at this point 2. Specialist intervention only justified if it can influence change for the child at this point 3. A presumption of episodic working, with children coming in and out of the service via discharge and re-referral rather than remaining on the caseload (active or on review) until their impairment has resolved
TOMS	Evaluation of outcomes needs to take account of: • Impairment • Daily activity • Social participation • Wellbeing
Triage	Initial conversations with parents and other interested parties establish who is concerned, why, what support is already in place, and what they are looking for from the service

In this chapter I will explore the two Candidacy dimensions, specialist SSD knowledge and therapeutic sensibility, and their key concepts. For each, I will use one example to show how depth made a difference to practice change and another to consider the challenge of bringing depth to Candidacy judgements.

7.2 Dimension: specialist SSD knowledge

This section introduces the specialist SSD knowledge concepts of impairment, intelligibility and suitable interventions, and discusses similarities and differences in depth of their application. I use formal assessments as an instrumental case before highlighting more generally how depth was or was not achieved.

7.2.1 Concepts: impairment, intelligibility, suitable interventions

No facet of Candidacy was straightforward, including what constitutes an impairment. Speech, language and communication are developmental phenomena, and every speaker is unique. Children's development varies, as do speech sound features of their languages, dialects and accents, and societal / individual acceptance of difference. There is no clear boundary between normal

and impaired speech sound development, and considerable uncertainty in predicting the long-term consequences of an impairment, either with or without intervention.

Impairment is not the only influence on how easily a child can be understood. Intelligibility can vary depending on the impairment, the linguistic complexity of what the child is saying, the familiarity and skill of the listener, the mode of communication (such as face-to-face or telephone), and background noise.

Although there is a lack of research consensus on SSD typologies, interventions have been developed to address particular profiles. Part of depth of specialist SSD knowledge for Candidacy was being aware of these links.

7.2.2 Applying specialist SSD knowledge

Taking impairment and intelligibility into account, children with milder SSD were not priority candidates unless this was a problem for them (see 7.3.1). Participants were trying to reduce the number of such children reaching their service or receiving direct intervention. Universal and targeted level initiatives included use of social media and consultation clinics, and pre-referral work in nurseries and schools. Participants accepted fewer referrals for children with speech sound delay (versus disorder), especially if they were easily intelligible. Some held off intervention for longer than previously, were stricter about developmental readiness, and delegated intervention for children with milder SSD to assistants or parents.

Children with more severe, persistent and disordered SSD were viewed as priority candidates but were not necessarily treated as such. Candidacy judgements were based on a process of assessment and analysis of the SSD, and planning and evaluation of intervention effectiveness. The depth with which this was enacted was closely related to how participants' SSD Intervention had changed.

I will illustrate this in two ways. First, I will compare use of formal assessments which differed in depth. Second, I will look at why depth in the specialist SSD knowledge dimension was important but challenging to achieve.

7.2.3 Depth: comparing formal assessments

Participants gleaned information about a child's Candidacy in informal and structured ways. Formal assessment tools helped to establish the nature of the impairment. Formal assessments are books of pictures designed to elicit a sample of single spoken words from a child aged around 3-7 years. The targeted words are selected to be familiar and to include certain sounds and sound combinations.

Formal assessments vary in type of images, depth of theoretical underpinning, extent of standardisation on populations, expected level of phonetic transcription, and tools for analysis of systemic and structural patterns. Differences in vocabulary across the English speaking world mean that, although formal assessment tools have a similar format, they differ in content between countries and continents. Most are commercially produced, but some are freely downloadable.

Participants had access to a variety of formal SSD assessments. Where SSD intervention was largely traditional, the CLEAR Phonology Screening Assessment or the South Tyneside Assessment of Phonology (STAP) were in routine use. Where practice now included non-traditional interventions, they had been supplanted or supplemented by the Diagnostic Evaluation of Articulation and Phonology (DEAP) and / or Caroline Bowen's Quick Screener (QS) (based on the Metaphon Resource Pack Screening Assessment).

To understand this pattern, I will explore what was made possible by the CLEAR / STAP, contrasted with the depth made possible by the DEAP / QS. I will then consider what it took to change from routine use of the former to the latter.

7.2.3.1 *What was made possible by the CLEAR / STAP?*

Many participants were happy to use the STAP, but spoke about the CLEAR with real affection. They liked its attractiveness to children, ease and speed of use, logical organisation, inclusion of expected age of development of sounds, and the potential to give immediate, understandable feedback to parents. [Morven] was typical:

> I think the pictures are fine for the children.. em.. I like the way you can RECORD.. what they're saying.. em... it goes through a developmental PROCESS.. em it's got your.. initial, medial and final.. um.. and it's got that LITTLE bit of an AGE guide at the side.. which I can.. find useful just for.. letting a parent SEE? You know? [[mhm]] 'that's OKAY for that age.. you don't need- that's, that's what it says there! that's what you should HAVE at that age, don't worry about things that you're seeing that are.. five plus'

While most had shifted from the STAP to the CLEAR, [Emily] preferred the STAP because it gave more than one opportunity to note how the child produced a target sound in a particular word position. She liked seeing all substitution patterns across the whole of the child's sample because initial impressions on a "flick through" were not the most reliable basis for planning intervention.

Some participants recognised limitations of the CLEAR unless the child had a mild SSD. [Jess] now realised it could mislead around what was "age appropriate". For [Aileen], it "does break down" when a child had a problem with vowels. As it requires sounds to be ticked rather than whole words transcribed, [Jayne] found it unhelpful for "thinking about what they're doing".

In the context of traditional Intervention and heavy Caseloads, the CLEAR's speed and simplicity appealed, but [Shona] believed this came at the price of being "relatively superficial" and not giving "ANY level of analysis" to help plan intervention.

7.2.3.2 What was made possible by using the DEAP or QS?

The DEAP and the QS encouraged a deeper level of analysis that helped participants tailor intervention and monitor progress. The DEAP had a diagnostic screener leading to a follow-up with a full phonology, articulation oromotor or inconsistency assessment. The QS incorporated intelligibility and severity ratings. Both the QS and the DEAP included measures of percentage consonants correct (PCC) and percentage vowels correct (PVC).

The DEAP held out the opportunity to identify a speech sound profile (such as inconsistent phonological disorder) linked to a suitable intervention (Core Vocabulary). Having previously assumed this "needed some magical POWERS", [Maureen] saw immediately "oh my goodness, this is a

DIFFERENT.. kind of PROFILE". The DEAP's visual feedback enabled [Niamh] to "PLOT… a child's speech sounds.. which we wouldn't have done in the PAST..", and identify a phoneme collapse which could be addressed with Multiple Oppositions.

Participants differed over whether the DEAP or the QS was quicker. Most tended to use the QS first, then use the DEAP if a more in-depth assessment was necessary, partly because the QS had a freely photocopiable record form. They also differed over which was most useful. [Erin] welcomed the QS's combination of percentage consonants correct (impairment measure) and an intelligibility rating scale, while the DEAP enabled [Wendy] to track subtle progress:

> a quick CLEAR would never show you the CHANGES [[mhm]] whereas actually the DEAP is so in-depth that even if you're not seeing.. MASSIVE amount of changes IN their overall SPEECH pattern.. you can begin to see on the DEAP changes with the kind of increase in the consonants CORRECT or.. you know.. changes happening in that becomes more sort of DEVELOPMENTAL looking versus kind of.. [[mhm]] ATYPICAL?

[Sophie] considered the percentage consonants correct tally and linked guideline severity levels in the QS a "brilliant" change in practice that "NOBODY" was talking about "three years ago". The severity levels helped [Niamh] realise why an intervention targeting fricative clusters was "working with THEM but not THEM". [Fran] agreed percentage consonants correct was "a VERY good plotting mechanism" and "very helpful" for feeding back to parents "he's now FIFTEEN per cent but he's moved from NINE?" that "would NEVER have happened" when using the STAP or CLEAR.

7.2.3.3 *What did it take to change from the CLEAR / STAP to the DEAP / QS?*

NHS participants had access to the DEAP, and [Blaeshire] had one in every clinic base. The QS was freely available online. Participants who used the DEAP routinely had been persuaded by their university lecturer or Jan Broomfield, Helen Stringer or Caroline Bowen via training events. Use of the QS followed recommendations from Caroline Bowen.

Access and awareness that the DEAP may provide a more in-depth assessment was not sufficient incentive to use it. [Emily]'s student used it because "it tested all the different areas" and had "specific… research behind it", but [Emily] could get the information she needed from a STAP. Even where staff were encouraged to use the QS / DEAP, [Sophie] noted some "really still LIKE the CLEAR".

This sense of reluctance was recurrent, even from participants who now used the DEAP routinely. [Maureen] thought "we've FORGOTTEN.. how HARD it was to get our heads round the DEAP? [[mhm]] I mean we all really.. s-struggled". Likewise, [Isla] confessed:

> I.. have always been a bit SCARED of the DEAP (laughs).. cos it.. had too many forms and… and I didn't really, you know, having read through the manual I thought 'I'm STILL not... clear on.. WHY I would be doing this' (pause) yeah, 'what-what forms DO I have to do, ALL the forms? ALL the children?' I just didn't KNOW and there was nobody that I worked with.. that used it either, though we had it.. in the.. clinic cupboard..

Even with the QS, "getting your head round" its elicitation tricks, process, scoring, tallying and charting was time-consuming, and took [Niamh] "repeated practice to be able to DO it quickly".

Whether referring to the DEAP or the QS, participants such as [Isla] extolled the benefits of planning and reflecting on implementation with colleagues in hubs, joint assessment clinics, or other networks:

> I think that support's really important.. cos you don't feel like you're on your own making a change and nobody knows why you're.. doing it.. least of all.. having the confidence in yourself to be like 'actually.. I'm gonna do something different from all the rest of my colleagues'..

7.2.4 Depth: the challenge

The challenges encountered in 7.2.3 echoed throughout Candidacy processes of assessment and planning. While credible knowledge brokers in the profession argued for depth, this had to be valued and modelled in *local* practice before it could be enacted.

Participants liked to do and be seen to do. [Jess] had to repress her tendency to make "QUICK" decisions, while [Hannah] reflected:

you know a way you can get into.. of [[right]] you COME to WORK and you DO. You know, you 'therap', don't you, you come to work and you DO. And sometimes.. you CAN feel... sometimes under pressure to get, to get things shifted, to get things moving, to get a change GOING? And sometimes I think I don't always take enough time sometimes at the start just to... really think.. [[mm]] HOW I'm tackling this, and WHY I'm tackling this that way.

NHS realities played a major part. In private practice, [Isobel] felt "more GROUNDED in what I'm going to do" because she had "MORE TIME.. for PLANNING". It also led [Aileen] to more tailored intervention:

quite often.. certainly within the NHS, whatever is in your BAG?.. or in the DRAWER.. when you're (laughs) rushing out the door.. em that sometimes if we've not PLANNED it very carefully that you just take up and then you can think 'oh we'll do this'.. and I DO notice the difference say with my private work that I'm.. PLANNING.. more carefully, and I'm THINKING more about how to fit it in with what's already happening

However, time spent on assessment and planning rather than therapy was also viewed as an indulgence. In spite of sustained advice to give more time to assessment, [Sophie] found this only happened once people saw for themselves that it made a difference to outcomes:

'I GET it NOW!!.. (laughing) because I've tried to just jump straight to the approaches and the different target selection... mmhm but I keep finding children it's not WORKING for so you're right, maybe I need to go BACK and invest more time.. on.. REALLY THOROUGH assessment.' (pause)

Pressure to 'do' could also come from parents. [Jess] noted, "you could TELL they were just wanting you to get STARTED". Having come to see extra time on assessment, analysis and planning as an investment, [Paula] argued the therapist had a responsibility to explain it because if "WE value it" then "THEY value it". [Niamh] found a parent was happy when she deferred a block of therapy by a week to allow time for planning, but it took "confidence to DO that".

Experience led some to question if they were spending sufficient time on Candidacy. [Elizabeth] wondered if some of her disappointment in non-traditional SSD interventions was down to "not.. doing a FINE ENOUGH GRAINED assessment (laughing) at the beginning". [Natalie] was asking if too little time on assessment resulted in children getting "MISSED and then they

end up on the.. caseload for AGES" having spent months unnecessarily "not being able to DO something".

However, therapists had few role models to go on, and pre-qualification experience did not sufficiently challenge the status quo. [Erin] recalled that university training "didn't go PAST… assessment?" into decision-making and [Natalie] observed the value of planning was hidden because practice educators felt they had to "fill up" placement days "with kids". She felt planning was the "HARDEST" bit of the intervention process because "you're THINKING about it yourself".

The work of planning was therefore essential to Candidacy, but was often invisible and carried out in isolation. In contrast, [Wendy] found being based in a clinic with colleagues rendered planning more visible, social and valued:

> now actually because we're all in the OFFICE there's lots of.. sort of ad hoc discussions and things about children, families and actually.. THAT kinda conversations have been really useful [[mhm]] for kinda PLANNING and things like that.

7.3   Dimension: therapeutic sensibility

Candidacy judgements were not just about starting therapy, but continuing with it and ending it. In this section I will explore these judgements in relation to the concepts of impact, motivation and risk. After using the tensions of episodic intervention to demonstrate how these concepts were applied with more or less depth, I will discuss how a social perspective appeared to make a difference.

7.3.1   Concept of impact

To take account of impact, therapists had to accept that different children and different parents would respond differently to an SSD and to the prospect of intervention. [Nicole] was thinking "more and more" about what was important to a child and their family, who was best placed to intervene, and if now was the right time:

> so like in our case history.. the front sheet.. what is the concern of the parent? (pause) that's really.. the priority [[mhm]] .. whereas before it was 'tell me about your pregnancy (loud laughter) and the birth' [[yes!]] and.. [[(exclamations of agreement)]] so it started with.. it was very medical

model and.. we.. we.. we still need to KNOW these things, we still ASK those questions but.. we have ANOTHER layer now as well.. [[yeah]] which is to do with.. 'and how is this affecting YOU [[yeah]] and how is this affecting the CHILD?' [[yeah]] and.. 'how do you KNOW they're getting frustrated' [[mhm]]

Triage meant these discussions could take place before a child even reached therapy. The mum of a teenage boy who was "not coping with life GENERALLY" decided after a "good bit of discussion" with [Sally] that "it wasn't the right TIME":

> And she was REALLY GRATEFUL. You know. That we'd had that discussion, but it would have been.. what would have happened before.. is that HE would have come into clinic, NOT WANTED to have been there.. because she SAID he didn't want it.. [[yeah]] em and actually would have added... hh pressure and stress on to HIM.. and it WOULD have been I think very NEGATIVE for him.. AT THAT TIME. Whether he comes BACK to us I don't know.

[Erin] found some parents were surprised to be asked their opinion. Rather than taking on the "roles" of the therapist telling the parent what to do and the parent doing it, both had to act differently. [Erin] now thought much more carefully about who she was taking on, while [Iona] found ways to elicit what really mattered to parents:

> we ask them to rate their CONCERNS on a scale of one to ten? And sometimes just.. it seems like a funny question and parents say 'oh! okay, well a five' but they, if you leave a LITTLE gap.. they usually always explain that reasoning, and it's the.. explanation that follows that is really what's useful.. they say 'I'm a five.. beCAUSE.. I'm not, I-I don't struggle to understand them every day BUT they're starting P1[31] in..' and that's the REAL concerns often you get a little bit more out of them rather than saying, 'so ARE you concerned about your child?'.. no or yes

Throughout intervention, therapists now tried to find out if therapy was having an impact on the impact as well as on the impairment. [Niamh] wondered what it must have been like in the past:

> obviously there is an impairment there and that is wh- [[yeah]] why we have a JOB and.. you know.. it's not to.. to-to DISMISS that in any shape or form but.. em... I suppose HISTORICALLY.. prior to thinking about

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[31] Primary 1, the first year of school in Scotland when a child is usually aged 5

IMPACT.. you would have just kept on working on EVERYTHING?.. but actually were you making... how much difference were we making?

A close relationship with parents made it easier for [Wendy] to spot "the kinda STATEMENTS" that showed how the SSD and intervention were having an impact on a child beyond the impairment. [Paula] gave examples: "He put his hand up and answered a question in assembly yesterday"; "his big sister's friend made a comment and he was really upset". Some participants made additional efforts to gauge children's views directly. [Beverly] had used Talking Mats for:

> kind of thinking about.. OUTCOMES.. from HIS point of view from.. em sort of a participation point of view.. from.. and things.. and around his sort of attitudes around his talking.. em interacting with his FRIENDS, things he feels he's GOOD at, things he feels he STRUGGLES with..

7.3.2 Concept of motivation

The impact of an impairment on a child and family was closely related to their motivation to do something about it. Using a child with a lateral <s> as an example, [Niamh] suggested being "BOTHERED" provided the necessary motivation "that makes therapy more SUCCESSFUL".

However, taking account of motivation to act was not intuitive, and [Jess] had had to learn to trust the process. If parents weren't "ready to engage" she used percentage consonants correct and linked severity levels from the QS so at least "you're GIVING them the information they need to make a decision", but this could leave her frustrated:

> you can get these kids who have got a whopping speech sound disorder.. and it's NO impacting on ANYBODY.. I sometimes find THOSE a bit hard to give up, cos I just think 'oh I could totally DO loads of stuff (laughing) for them!'.. but again sometimes they've gone away and they HAVE come back at a.. a more right time for the family...

To help with Candidacy judgements, participants now took into account what a child and people around them were already doing to address the perceived problem, and what they would be willing and able to do in relation to therapy. [Rowan] got "a LOT of information" in Triage telephone conversations with

parents, and realised this had filled a service gap she had been unaware existed:

> we would get REFERRALS in.. we would.. instantly jump to em ASSESSMENT mode.. without actually looking at what the problem was.. what-what support was already in PLACE for the child, if there WAS any.. support in place. Em.. how-how could we skill up parents? We MISSED out that whole BIT and just jumped straight to ASSESSMENT. [[yeah]] And it WASN'T.. effective

This conversation could also lay the foundation for a child and family's motivation for intervention. [Grace] found it particularly valuable for the "self-esteem" and "confidence" of children with more severe SSD because she could:

> give that advice to parents about.. um... the importance of that, you know the importance of COMMUNICATION rather than SPEECH.. for those kids. Um.. that.. at a very, at an EARLIER stage. You know, yes, we'll GET to you. This is what you're going to do in-in the meantime. And so... by the ti- hence by the time they GET to us.. then we don't have to sort of.. spend.. quite a bit of TIME.. you know.. SHORING that up again..

If other people around a child were not willing to support therapy, Care Aims supported participants to be more realistic in what they could achieve on their own. Although "poor" speech was important to therapists, [Jayne] found it was not always a priority for others when a child had "lots of other social issues". Care Aims helped her think through and negotiate how she could make a difference, which might include "some symbols" and helping that child "ACCESS the environment" rather than direct impairment-focused intervention.

7.3.3   Concept of risk

When a child was bothered by their impairment, therapists were motivated to help because of the risk this posed and the unique skills they had to address it. [Isla] felt children who were "frustrated" by or "aware" of not being understood deserved intervention so they would not be "left.. struggling with all the IMPACT that that has on their.. LIVES" such as behavioural and social consequences at home and nursery.

Risk was, however, challenging to judge. Participants recognised that some children would progress without intervention. Not having intervention might be

harmful for some, and not having the right kind of intervention might delay progress. Intervention was sometimes inappropriate, and on rare occasions harmful to a child's wellbeing.

[Erin] found Therapy Outcome Measures (TOMS) practical for risk judgements, as it "helps you SPLIT up the impairment" from other Candidacy considerations to guide "whether you need to DO something.. or not". [Sophie] felt TOMS also guarded against the possibility of impairment considerations "potentially getting lost" in Candidacy judgements. Using a hypothetical example of a child with a considerable SSD but no impact on activity, participation or wellbeing "at the moment", TOMS would highlight that "you're dealing with RISK" and lead her to ask, using Care Aims, "is it a risk for US or is it.. a risk for somebody ELSE".

The idea that speech and language therapists could consider a child's speech a risk for somebody else did not always go down well. [Rhona] noted people could get "ANNOYED or UPSET or.. dissatisfied" if intervention did not "go down the impairment.. road", and that changing their expectations was "a drip drip.. process". Care Aims had "ALLOWED" [Shona] to hand back "duty of care" once "we've done our bit", but this could be interpreted as an excuse to discharge a child.

[Megan] argued for an additional "clinical kind of.. intuition" around risk. The Risk Matrix (part of Care Aims) had exposed low motivation which indicated that an older child with severe SSD was no longer a candidate for therapy and should be discharged. Instead, [Megan] used it to think about how his motivation for intervention could be increased, and suggested a period of people around him raising his awareness of his poor intelligibility instead of "pretending that they understand him".

7.3.4 Depth: the tensions of episodic intervention

To help explain how depth of therapeutic sensibility contributed to different trajectories of practice change, I will now consider tensions around the practice of episodic intervention. Tracking back historically to T1 (the context that moved people to action at T2) (Table 2-2), children with SSD were originally seen as candidates for continuous intervention, moving from one sound to the next. As Caseloads expanded, this became unsustainable. Participants were generally

no longer intervening continuously until the impairment was resolved. [Jackie] now felt "a lot HAPPIER" giving children a consolidation break, discharging them, or holding off intervention than she had "ten years ago".

However, there were subtle differences in episodic intervention practice depending on whether the Candidacy or Caseload aspect of the practice context was perceived to be the primary driver, and the line between was fuzzy. Episodic working for Candidacy was more about ensuring intervention could be effective at a particular time for a particular individual. Episodic working for Caseload was more about providing an equitable service to people who were judged to be candidates for intervention.

Episodic working for Candidacy required careful planning of an individualised episode of care, which could include blocks and consolidation periods. Rather than staying dormant on the Caseload when therapy had gone as far as it could, the child was discharged and parents encouraged to re-refer when intervention could again make a difference. In relation to one child, I remarked it must have been "difficult to DISCHARGE someone who's backing[32]", but [Erin] explained that, after speedy progress:

> he wasn't moving ON, he wasn't making PROGRESS so... I decided to DISCHARGE him and give him a s- and I've [[mhm]] said to mum around about six months [[mhm]] I think he'll need to come BACK?... but I've done that.. bef- I would have NEVER have done that before [[no]]...

For [Jess], even the idea of consolidation breaks had been strange:

> I would NEVER give a kid a consolidation break before, so that whole ble- breaks and blocks thing? (pause) definitely for me.. like.. has made a difference, and within an episode of care, d'you know, I'm.. and I'm very much like that at the beginning 'so we'll do ten sessions, d'you know, then we'll maybe give you six weeks off and then we'll COME in and we'll see, because they need TIME to consolidate, and blah-di-blah-di-blah'... I woulda just gone 'right we're finished doing <k>, right now we'll do <g>'

Episodic working for Caseload carried an expectation that therapists would use 6-10 weeks blocks-with-breaks as standard to maintain service equity. [Vivienne] had experienced this shift in expectation less as a constraint on her

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[32] A term for a disordered speech pattern

agency than a "weight off your shoulders" because the responsibility to "fix" speech was "an unrealistic load to carry", and it enabled her to hand over some responsibility to families. [Emily] tried to maintain some flexibility:

> you're supposed to work in the blocks like that (pause) I can be a bit variable in my blocks. Like there are some children who are incredibly unintelligible, and they're going to SCHOOL in August! And.. I'm like 'oh! we could just do with doing another block again, you know, and.. carrying this forward sort of thing, keeping the momentum going'...

Whether Candidacy or Caseload was perceived as more salient, discharging before the impairment was resolved was now uncontroversial. [Lorna] recalled that the early days of Care Aims contributed to discussion about "NOT EXPECTING the child to be a hundred per cent perfect BEFORE you discharged". Therapy Outcome Measures also helped some participants make this judgement. [Sophie] explained that each TOMS category (impairment, daily activity, social participation and wellbeing) was scored on a scale of concern from 5 ("totally normal") to zero. A TOMS score of 4 on impairment ("maybe a few persisting immaturities and or one delayed process"), with no problems highlighted in the other sections, would "TOTALLY" be a discharge.

Discussion around discharge when a child was not making progress but still had a significant impairment was more emotive. Where Caseload was perceived as more salient, participants could experience considerable anxiety about being expected to discharge children with severe SSD for lack of progress, especially when they were otherwise unsupported. With other types of communication difficulty, participants felt distributed responsibility for intervention made sense. However, [Megan] was typical in saying "speech IS.. is US". She talked of "someone that I.. could never DISCHARGE", because "I don't think I'd sleep at NIGHT knowing.. that.. he.. wasn't involved with speech therapy". [Vivienne] also commented on "the issue of hard-to-reach families". Being encouraged to say "Sorry, then I'm OUT!" if there was no support for therapy led to the problem of "we ALL know it's the same kids who lose out again and again that way".

Where Candidacy was perceived as more salient, [Carolyn] emphasised such a decision was "not supporting DISCHARGE, it's supporting.. being EFFECTIVE

and.. [[mhm]] timely". She believed it offered "a PROTECTION" to therapists, because having a child on the Caseload who was unsupported and not making progress could leave "YOU feeling VERY depleted":

> if we've really been.. through every avenue.. to TRY and get the best support for that child but we CAN'T because the timing's not RIGHT.. then it, I think it's quite a relief to know that, well actually.. although it's regrettable.. [[mhm]] we're going to discharge at this point in time, and it sounds HARSH but.. you can't carry.. [[yeah]] you could carry (overlapping) SO many children that you can't be so effective with it

Megan observed pragmatically that discharging a child when SSD was the "obvious problem" could lead to a complaint. Critical Incident Analysis of complaints in one area had highlighted that staff needed to take more account of the patient's *story* when considering impact, motivation and risk, and [Sophie] wondered if this could have been an unintended consequence of the Care Aims "pressure" only to be involved when you can "influence CHANGE".

7.3.5 Depth: the need for a social perspective

The demands of bringing depth of therapeutic sensibility to Candidacy judgements were considerable. [Audrey] contrasted an imagined "comfortable" time in clinics with children and parents with the "FRENETIC?.. way of working" therapists now faced to decide "where can I make my largest influence?":

> it's moved on a lot, and I think our expectations of the therapists and on.. of them.. CHOOSING which route to take.. and us trying to influence.. their choice (pause) is a big.. a big step ON... [[okay]].. actually. (pause)

[Grace] reflected greater depth had involved "fighting" our own "view of OURSELVES and what we should be DOING" as well as changing other people's expectations.

Clinical decision-making tools and frameworks had helped participants, not just with their Candidacy thought processes, but with the associated dialogue and conversations. There was, however, considerable variation in the strength of commitment to supporting and sustaining their use with fidelity across the different Services. Among participants who also had experience of working in other areas, there was no doubt that [Blaeshire]'s use of Care Aims as intended was thorough and advanced. What [Pam] referred to as the Care Aims

"philosophy" was deeply embedded in practice, and supported and sustained by initial training for all new staff, advanced trainers, peer facilitation, and a development team. As a consequence, [Blaeshire] participants were well used to discussing and defending their practice as well as reflecting on it.

This social approach to introducing new ideas around Candidacy and then, as [Shona] put it, constantly "keeping it LIVE" appeared to be key. It was interesting that where participants were most enthusiastic about Triage, they had also had the opportunity to implement it with colleagues. For [Hannah] this had been a revelation:

> the things that were.. really good about it was WORKING with someone ELSE cos we're.. 'on our own'.. I'm on my own ALL the TIME... em there's one, maybe one day a week where there's someone physically else in an OFFICE but the rest of the time.. I'm ON my OWN. [[mhm]] em.. and just that.. I think you... you GAIN so MUCH from working with.. someone else, it was SO rewarding, SO positive, I got SO much out of it that I hadn't expected.. to GET?

This included knowledge exchange about different client groups, feedback on practice, the opportunity to see different "STYLES" and the chance to discuss any anxieties.

[Vivienne] observed it was possible to change "who we see" without "necessarily changing the THERAPY we do", and this was key to noticing that Intervention and Candidacy were different aspects of the practice context for change. However, depth of the therapeutic sensibility dimension of Candidacy may make it more or less possible to change the Intervention aspect. As [Shona] reflected:

> I don't think people would have examined their PRACTICE.. to the extent that would have left them feeling something needs to CHANGE... without Care Aims.. thinking. (pause)

In addition, although "maybe.. to a LESSER degree",

> the fact that people are being asked to actually MEASURE.. their OUTCOMES.. em... as well.. you know.. [[okay]] has ALSO been instrumental probably in PROMOTING the change within phonology intervention...

7.4 From Candidacy to Caseload

The political and ethical dimensions of judging whether a child was a candidate for starting, continuing with or ending therapy (and what that therapy should be) added further complexity to the work of providing SSD intervention. Participants had to use their specialist speech and language therapy knowledge and bring a therapeutic sensibility to their Candidacy judgements.

Although children with more severe SSD were viewed as a priority, whether or not they were treated as such depended on how specialist SSD knowledge was applied to assessment, analysis, planning and evaluation of impairment, intelligibility and suitable interventions. While credible knowledge brokers argued for depth, this was not necessarily modelled or valued in practice.

Moreover, rather than a duty to intervene if a child had an SSD, participants now had a duty to use their therapeutic sensibility to judge whether it was right to intervene in spite of the impairment. Clinical decision-making tools structured thought processes and conversations around impact, motivation and risk, but differences in how deeply these were supported and sustained created key differences for the trajectory of practice change.

Children who were judged candidates for the specialist involvement of a speech and language therapist became part of a clinical Caseload (usually after a period on a waiting list). The next chapter will explore the Caseload aspect of the practice context.

8   Caseload aspect of the practice context

8.1   What Caseload is, and why it is relevant

The Caseload aspect of the practice context referred to clinical caseloads made up of people judged to have Candidacy for the specialist Intervention of a speech and language therapist. Consisting of individual cases, they were also a whole. As caseloads belonged to a therapist but also to a Service, they were a site of tension for practice change.

Almost all participants only saw children. Caseloads varied in their balance of generalist and specialist responsibilities, commitments to universal or targeted work, and the degree to which they were shaped by fixed days at particular schools or clinics, a part-time role, or a clinical interest. Managers varied from having no clinical caseload, through taking on this responsibility intermittently, to carrying a caseload alongside managerial duties.

Four dimensions of the Caseload aspect were most relevant for SSD practice change: size, composition, the time clients spent on the caseload and distribution of work around having a Caseload (Figure 8-1). Variations in how these were addressed created key differences for the trajectory of practice change.

Figure 8-1: Caseload dimensions
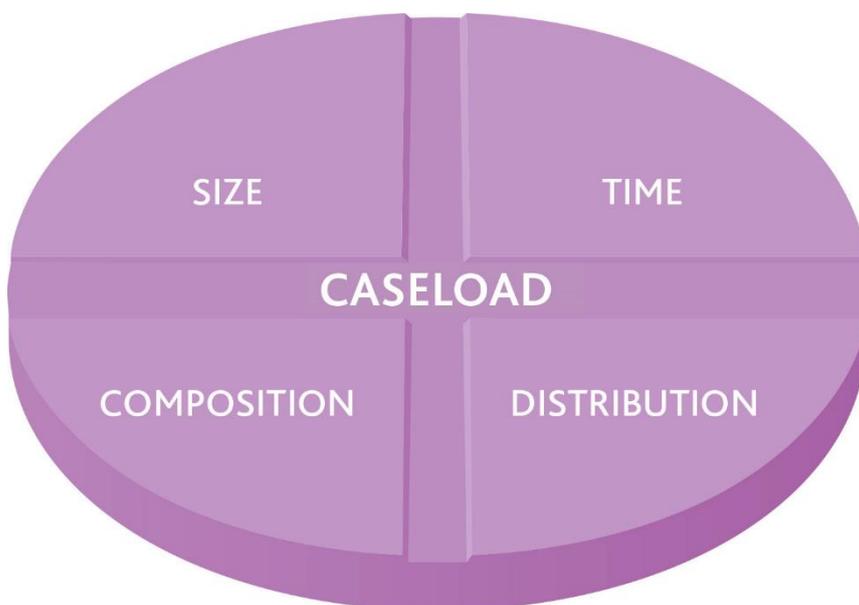
In this section I will consider why caseloads mattered to participants and introduce the four dimensions. I will then explore each dimension to show why Caseload has to be integral to any discussion of SSD practice change.

8.1.1 Why caseloads mattered to participants

Participants conveyed pride, satisfaction and protectiveness around clinical caseloads. [P3] moved from an increasingly pressurised and bureaucratic NHS to private practice "because I wanted to get back to doing what I love the most, and that's giving children therapy". Compared to therapists working elsewhere in the NHS, [B17] felt "lucky" still to see children for regular direct intervention "because that's why I went into this job..".

[B7] contrasted management meetings with clinical work where "you actually feel very COMFORTABLE and feel very HAPPY because you can see an immediate.. benefit?" She retained a clinical caseload to have "credibility" with staff, but observed their focus on "the most important thing to me is… my caseload" sometimes prevented them bringing themselves "back UP, you know, to the whole picture". [C7] used meetings about caseloads to encourage staff "to think wider than just THAT CHILD" to working with the school or nursery more generally.

While work beyond clinical caseloads was expected, some participants were not convinced it was valued. [B5] said, "you HAVE to acknowledge" that time spent building capacity meant "you're spending time away from your caseload". Supporting universal services meant [B1] was "doing a lot of WORK.. for children that AREN'T on your caseload". Although she understood "it's to sort of maybe DETER children from COMING on the caseload", this wouldn't show up in statistics.

The word 'caseload' was used somewhat pejoratively to differentiate practice changes of process from those involving therapy. [S5] was experiencing "loads of practice change, but it's maybe kind of.. LESS on the side of therapy and more kind of on the side of.. em how we're managing our waiting lists.. and the CASEloads and things..". She got the impression that thinking about SSD *interventions*, while "it feels important to ME", was "a bit of a luxury?"

Caseload commitments affected how new Intervention ideas were received. [B8] understood people could "panic", and [B16] found it challenging to take on board and organise intervention changes "WHEN you're… running with a heavy caseload" and "people still need to be SEEN".

8.1.2 Caseload dimensions

Four Caseload dimensions were particularly relevant to SSD practice change: its size, its composition, the time clients spent on it, and the work of a caseload (Table 8-1). These dimensions were neither predictable nor controllable, but contributing facets were open to influence.

Table 8-1: Caseload dimensions and contributors

Dimension	Contributor
Caseload size	Caseload numbers
	Interpreting caseload numbers
	Responses to caseload numbers
Composition of caseload	Caseload scope and its consequences
	Implications of the ratio of SSD severity
	The impact of unpredictability
	The need for caseload equity
Time on caseload	Time on caseload as culture
	Time on caseload as outcome
Distribution of caseload work	Therapist taking responsibility
	Manager taking responsibility
	Hub[33] taking responsibility
	Service taking responsibility

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[33] Services were organised as areas, divisions and hubs

8.2 Dimension: caseload size

Caseloads varied in size and what these numbers meant. There were also different ways of responding to high numbers, which had implications for practice change.

8.2.1 Caseload size: numbers

Caseload size in [Staneshire] and [Clootshire] contrasted sharply with [Blaeshire], where numbers were capped and ranged from 25-35. Private practice caseloads were much lower.

[S4] had a caseload of 53 but said others locally had "DOUBLE". [S10] reported other [Staneshire] divisions had caseloads of around 70 and 90. In [Clootshire], one caseload was 50 in a 0.4 job, while [C1] had had schools, nurseries and geographical patches added bit by bit over the past few years, giving her "more and MORE.. to DO".

Some participants had experienced a reduction in average caseload size, and all were aware of variation. [Blaeshire]'s caseloads used to be 130-150. When [B3] qualified, her peers in other areas had caseloads of 200. [B12] observed:

> what you mean by 'a horrendous caseload' now.. is very different to what I thought [[yeah]] a horrendous caseload was when I STARTED [[yeah!]] cos.. [[yeah]] you had like.. a HUNDRED and twenty CASES [[(general agreement expressed quite loudly)]] on your desk to DO and.. you'd just to get ON with it!

8.2.2 Caseload size: interpreting numbers

Benefits of a smaller caseload included the feeling of doing a better job. [B6] was "spending LONGER in sessions" and [B17] could "achieve better with.. the kids.. who I can help at this point in time?" [P1] was more "INNOVATIVE", encouraging parents to email her between sessions.

In a previous job, [B17] had "double" her caseload of 32, so knew "it's just not practical to be able to [[mhm]] really.. work with these kids in the way that you can work with... half the number (laughs)". However, in making sense of the Caseload aspect, size alone was not meaningful. [C5] explained "you can have a much LOWER NUMBER.. but more.. complex children.. and feel the same

strain (pause)". [B5] explained why, in spite of lower numbers, local caseloads were demanding:

> our caseloads are.. maybe would be considered SMALL, when I, when I started my ca- you know fifteen years ago my caseload was really really HIGH.. but.. the caseloads are SMALLER now, but they're actu- they ARE really complex, like we don't have ANY children that... 'just' has a phonological delay.. they're all [[mhm]] disordered

[B11] observed it sometimes made parents "feel better" that a child was on the caseload "even if it's not making any difference". Larger caseloads could also give a misleading impression that children were receiving a service. [B3]'s contacts with caseloads of 200 "were just REVIEWING everybody", meaning that "every six months you're just going 'oh I'll just assess them and see what's happening!' (laughs)". A historical baseline check in [Blaeshire] discovered at least a third of children on review. [B10] saw this as:

> a huge RISK. (pause) em you know because people see:.. people THINK that that child's being MANAGED.. and that you're DOING something to manage the RISK.. and you're NOT. You're not doing ANYTHING. You're COLLUDING. With your COLLEAGUES.. about the fact that this child's staying on REVIEW.. and you're not actually.. actively MANAGING them..

As a consequence, review was no longer a category in [Blaeshire], and children were only on caseloads if therapists were able to have what [B18] termed an "influence". [B10] recognised this "INTENSE" commitment could be "WEARING" for staff. For [B3], it justified the caseload cap:

> a caseload of thirty five IS really high.. because.. EVERYBODY on your caseload needs help NOW…

8.2.3 Caseload size: responding

The pressure of numbers provoked a variety of responses from individuals and Services: compromise, an emphasis on throughput, and prioritising, with each contributing differently to practice change.

8.2.3.1 Responding by compromising

Participants often compromised in response to caseload size. Some cut time on assessment and planning. For [S10] it was a reason not to "spend too much TIME thinking.. about cases" because you "just need to DECIDE what you're

doing and get on and DO it (pause)". A "MASSIVE caseload" made [S13] "want to get through QUICKLY" by taking short-cuts such as ticking sounds rather than transcribing words.

[S5]'s caseload was "bigger than would allow" her to deliver interventions with fidelity. She tried to "give MORE of them SOMETHING", although her "preference would be to have FEWER (laughs) and do MORE". She looked for a "compromise" such as adding 10 minutes to the notional 30 minutes per child. Sometimes compromises were balanced by other benefits. [B16] introduced group Formats "as a way of managing the caseload.. but also with.. because it's quite nice for the children?"

8.2.3.2 Responding by emphasising throughput

Services encouraged a focus on throughput. [B7] helped out when a hub "wanted someone just to come IN, you know, see these kids for six months and get them off the books".

An emphasis on throughput could provoke strong reactions. For [C1], "austerity measures" had impacted on caseloads to the extent that

> I don't want to use the word 'vicious' but you're quite (pause) CLEAR about.. how long you WILL and WON'T work with a child..

When waiting lists were "MASSIVE", and the service "waterlogged", [S8] felt pressure to discharge people who "aren't necessarily… AT that stage of discharge just yet...". In recognising the "PRESSURE" of "moving people through caseloads", [S7] worried:

> there is a lot of HEART in it.. em.. and.. that's wonderful! Em.. but.. I think SOMETIMES the heart... hands out.. the sessions.. whereas they should, on occasions, be holding BACK because they're just.. giving too much.. and I don't want them being... over-run by it all.

[B6] however welcomed the Care Aims emphasis on "THROUGHPUT" (7.3.4) rather than "building up and building up" a caseload as new children came in. Instead of having "dormant" cases that "you don't need to [[mhm]] on the caseload and they don't need to be on it", she was now willing to discharge and say "you don't need this RIGHT NOW.. but come BACK to us". With "more children coming in and out", smaller caseloads could be maintained.

Where Care Aims was less established, letting go of inactive cases was difficult. [S4] acknowledged "I used to have quite a few at the back of the drawer (laughing)" but, as her service was "working to get that down" she was "trying to.. DISCHARGE them instead of keeping them".

8.2.3.3 Responding by prioritising

Although the point of Care Aims was to improve clinical decision-making (Candidacy), it had an effect on Caseload. When introduced in [Blaeshire], [B4] and a colleague realised over nine months that numbers were falling. At that time there were natural "highs and lows.. not any more!! (laughs)" but this was a genuine trend meaning "we were left with manageable numbers".

[B10] acknowledged the "DANGER" of people using Care Aims to "reduce caseloads and then.. manage their boundaries by saying ((puts on dismissive voice)) 'that's not my duty o' CARE!' (pause)". Services in this study appeared to be using Care Aims to different degrees to set priorities that would help to manage caseloads.

Participants from [Clootshire] talked about a "caseload prioritisation tool", with only one referring to this as "Care Aims". [S7] explained Care Aims was being rolled out in [Staneshire] to give therapists "a chance to work effectively… with those that are on your caseload rather than continuously spinning.. far too many plates". She said for some the process appealed, while others found it challenged their values. Implementation was difficult for [S13] starting with "a MASSIVE caseload" but, once under control, Care Aims worked well to bring children in-and-out of the service.

Compared to other places [B4] had worked, the sustained use of Care Aims in [Blaeshire] meant they were "SO FAR AHEAD in.. terms of using Care Aims and.. using risk and impact". [B14] agreed Care Aims had effected "a REAL shift in the service" in conjunction with building capacity for children with long-term communication problems associated with complex needs. This reduced caseloads as these children "don't NEE:D a therapist.. to be seeing them all the time" and were more appropriately managed with "environmental-based" support.

8.3 Dimension: caseload composition

Although SSD was still 'bread and butter', community caseload composition had broadened in scope with a higher proportion of children with more severe problems. The unpredictability of caseload composition and the challenge of making caseloads equitable for therapists also contributed to SSD practice change.

8.3.1 Caseload composition: scope

Participants repeatedly spoke about caseloads broadening in scope, and the particular impact of autism. [B7] recalled that, when specialist educational provision was replaced by inclusion, "caseloads were becoming more and more filled up with.. ASD[34] and so on? And so.. the therapists NEEDED those skills". [C7] was disappointed this "FOCUS on.. autism with.. EVERYBODY.. media,.. other professionals.." had "taken AWAY from" speech and language disorders.

Within caseload scope, SSD had relatively low priority for services and individuals. When [S11]'s division stopped accepting new referrals for a period to "CLEAR current caseloads", this did not apply to "fluency and feeding". [S7] suspected a child with SSD could end up "towards the back of the drawer.." because "actually.. it's not high risk" and "there are others on the caseload that are… PUSHING me to… to ignore this one slightly".

[S7] noticed caseloads with the broadest scope allowed new recruits to develop "more QUICKLY into stronger therapists.. with a better idea as to how to cope with a lot of things". However, [S9] confirmed this came at a cost as "you've got to work really HARD" to keep up-to-date "with your ASD knowledge, your.. speech knowledge, your language knowledge, your STAMMERING knowledge". In this context, [P3] felt a child with *severe* SSD had come to be "a bit of a STRESSOR (pause)".

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[34] Autism Spectrum Disorder

8.3.2 Caseload composition: severe SSD ratio

Although all were moving away from minor SSD, some had moved further than others. [B10] believed there was no reason to have "easy" cases on caseloads, because "why would they NEED you?" [B13] reflected:

> gone are the sort of... velar fronting kids that just needed a bit of.. Metaphon type of thing, and they've been replaced with really... quite significant?.. persisting speech sound disorders?

This shift had been instrumental in [B13] doing "a lot of reading and a lot of research" about "evidence-based practice for.. what we're DOING with the kids". For [B2] the increased ratio had not come about by chance, but following years of "capacity building stuff that [[mm]] has CHANGED [[mhm]] what we get in our.. in our caseload referrals". [B18] found a screening tool for teachers was "kinda helpful.. in terms of managing a caseload [[yes]] and not getting inappropriate referrals", and it was now rare for children to come for SSD assessment who were "NOT appropriate".

Referring to the percentage of children with SSD on community caseloads (4.2.4), [B20] argued "we CAN'T HAVE" that proportion of our work "NOT being evidence based". As [S1] said, more difficult cases didn't necessarily "stand out" as most in need of help. However, it appeared to take an increased ratio of children with what [S12] referred to as "VERY ENTRENCHED.. multiple.. speech sound difficulties and.. em... and yeah, really quite unintelligible speech" to draw attention to the need for more effective Intervention.

8.3.3 Caseload composition: unpredictability

While community therapists' caseloads always included children with severe SSD, overall composition was less predictable. [S11] for example had gone through "a phase" of having "an awful lot of TEENAGERS" which created "a whole other set of challenges", including the largely preschool set-up of the clinic.

The potential contribution of parents was also difficult to predict. [S2] noticed a difference in openness about homework, from "pfff, don't have TIME" in one caseload to "they'll.. nod and.. smile and.. tell you they'll do it" in another. [B6] found parents in her most recent caseload were "more CAPABLE.. of doing

more at home?" [S8] felt a parent workshop was "pitched WAY too high" for her caseload, and doubted they would remember "one individual strategy that would have helped their child".

Even though community caseloads always included children with SSD, [B8] noted colleagues not only had "varying degrees of.. of success" implementing non-traditional interventions but "varying.. kids that they've had through on the.. their caseloads in terms of opportunities to TRY things". [B16] felt "the SOONER they come up.. after training.. the BETTER it IS". [B3] agreed her "chance to.. to do something DIFFERENT" came when a child with a severe SSD arrived on her caseload "SOON after" the training.

8.3.4 Caseload composition: therapist equity

Although its contribution to practice change could only be inferred, Services were conscious that Caseload composition had to be equitable for therapists. [Staneshire] and [Clootshire] were both addressing this, while [Blaeshire] had already done so. [S7] explained:

> I mean we can't have a... band six therapist in.. em.. [Staneshire B] working with.. a hugely MIXED clientele em.. and have a MASSIVE caseload and then you've got a band six say in.. [Staneshire A].. with a... a simpler caseload, which is half.. the size.. you know it... that's not RIGHT. (pause)

[C4] was not doing this to "a FORMULA", but by looking at whole time equivalents as a baseline and considering contextual factors in a "fluid" way. This included the practicality of covering a geographical patch, which for [C6] could entail "CONSIDERABLE distances and time including, you know.. boat journeys".

[B5] recalled that the "mental HEALTH" of therapists and economic realities of clients' lives influenced [Blaeshire]'s approach. As the impact of austerity gathered pace, they had looked for a solution that was:

> EQUITABLE and that's FAIR on your colleagues, that you've not got one person that's sitting with.. [[mhm]] FIFTY complex.. cases.. and another person [[mm]] that's just.. in a maybe more AFFLUENT area has got different.. NEEDS in that area, and their caseload's LOWER? [[mhm]]

8.4 Dimension: time on caseload

Time on caseload contributed in two ways to the trajectory of SSD practice change. One was the extent to which a long duration was accepted. The other was how reduced duration motivated therapists to sustain change.

8.4.1 Time on caseload: culture

[S1] commented that the speech and language therapy process was generally "NOT a quick fix". Historically this had contributed to a culture of acceptance that children could be on caseloads for a long time. [S12] remembered "you'd have kids on your caseload forever.. really..", and [S13] referred to Care Aims as ensuring "you don't.. have that child on your caseload.. for twenty years (pause)."

For some, this culture persisted in relation to children with severe SSD. Rather than being encouraged to try other interventions to bring about faster progress, [S1] was told younger therapists "don't stick to things long enough", and [S5] was reassured "we ARE just there til the kid's eight and that's the way it is and it's alright".

[B3] agreed it was "tricky" but felt it was important to balance motivation to stick at therapy with:

> motivation to get them off your caseload quicker as well, and no have them hingin' aboot for ages and they start calling you MUM and everything! [[AVRIL (bursts out laughing)]] I was like that ((pulls face)) 'ah right, we've known each other too long!!' d'you know, THAT kinda thing.. and I totally have a thing about.. this is one stuck in my head that Kate Malcomess[35] once said.. for a Care Aims.. 'if.. you get loads of presents.. at Christmas.. you're not doing your JOB properly' [[AVRIL (bursts out laughing again)]] so I TOTALLY have a thing about 'oh my god I need to get him off the caseload!! Before they start buying me Christmas presents!!'

Time on caseload drove some participants to question whether current Intervention was sufficiently effective. [S11] indicated by changing to a whisper that it can be tricky to admit "this actually isn't working we need to do.. to do something.. to do something different". [B10] recalled that having children with

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[35] Founder of Care Aims

SSD on caseloads "forever and a day" caused some therapists "discomfort" and "dissatisfaction", which started them "reading" about intervention options.

[B8] speculated that the possibility of getting children "off the CASELOADS quicker" had spurred her management team's investment in non-traditional interventions. They were:

> always quite (pause) CAREFUL at looking at.. 'okay so this child's been on for four years. WHY?' (laughs)

[Blaeshire] managers monitored caseload size on a monthly basis. If numbers were creeping up, or children had been on caseloads for more than a year, managers called the therapist to discuss the reasons. [B10] felt this helped therapists realise when they were avoiding "the difficult.. conversation they need to HAVE".

8.4.2 Time on caseload: outcome measure

Average time on caseload was not on its own a meaningful measure of effectiveness. [S2] was concerned managers were trying to work out the "AVERAGE number of sessions it takes to.. fix or… close a case.. for a child with speech sound disorder" because it made "NO distinction" between children with SSD by severity or complexity.

Time on caseload was also inherently unpredictable. [B18] had three apparently similar children referred, but the one expected to respond quickest was on the caseload for two years longer than the others. Similarly, the length of [P2]'s involvement with twins differed, although their SSD was superficially the same.

Service also made a difference. [P1] compared the time on caseload of children with similar SSD in private practice versus the NHS:

> so effectively two and a half years. And I had another boy, very similar, in the NHS. Well I kept that boy.. now again, Avril, that's.. you know I was a less experienced therapist so.. you've got to take that in mind as well.. [[mm]] I had him for SEVEN YEARS. (pause) Now I couldn't OFFER him, I TRIED... (laughs) I couldn't OFFER him what I've offered this other family.

Time on caseload was a more reliable outcome measure in [Blaeshire] because SSD intervention was targeted on those with the highest Candidacy before non-traditional interventions were introduced. Although routine data had not been

formally compared, [B10] observed "we're starting to see it in length of time.. people stay on the CASELOAD.. it's definitely SHORTENING.." and [B3] remarked "our files are also much THINNER because they're not SEEN for as long!"

Children could still be on the caseload a considerable time; [B16] mentioned one of "three or four years". However, [B3] had a child for "a year and five months" who previously would have "been on for YEARS". [B7] had one "on the books for over a year. Just over a year. But I would.. I think in the past I probably could have maybe added another six months to that?" For [B18] it was more mixed:

> I'VE been told.. 'the NEW stuff.. is what's gonna CHANGE THESE KIDS more QUICKLY so, it's more EFFICIENT.. it's more clinically EFFECTIVE.. it's better for the NHS, it's better for the CHILD, GREAT, so that's what I need to be DOING. But recently I've been finding.. it's NOT.. ALWAYS working.. that way. BUT it definitely makes SENSE.. I am seeing the FRUITS of it? Not ALL the time, but MORE to the stuff previously.

Seeing children move "off the caseload faster" gave [B20] a renewed sense of optimism about what she could achieve:

> in the PAST I'd get the kid on my caseload that had a-a you know, a-a REALLY severe speech sound disorder and for me there was an immediate.. .hhh I'm still gonna be seeing this child in primary five! kind of.. feeling... em.. whereas now I see a speech sound disorder like that and.. I DON'T feel like.. they're still gonna be on my caseload in primary five, I feel like, you know, if I get them at three it's almost a case of... I think I can have this child off my caseload before they start primary one, which is gonna make their.. schooling and the phonics and everything... easier for THEM. (pause)

[B10] noticed this reduction was not only motivating for therapists, but had "RAISED the credibility… of phonology work as well..".

8.5 Dimension: distribution of caseload work

The organisational work of a caseload was more than the sum of its parts. Beyond individual cases, it included dealing with referrals, prioritising, waiting lists, appointments (Triage, assessments, intervention), logistical aspects (space, equipment, group arrangements, travel) and reporting statistics. Around

a clinical caseload, participants also had to organise universal and targeted work, and build capacity (e.g. through offering training to other professionals).

The extent to which decisions about different facets of caseload work were *primarily* the responsibility of an individual therapist, a hub, a manager, or a Service varied, with consequences for SSD practice change. Complexity was increased by the number of possible facet-of-work / responsibility-for-decisions combinations, and the permanent flux.

Table 8-2 illustrates three scenarios of caseload work distribution, showing where the *primary* decision-making for each facet lay at the time of fieldwork. Each example is from a different participating service. Although there were within-service differences too, I purposively selected the examples to show maximum variation. With that in mind, the consistency of the therapist's responsibility around the *individual intervention* facet of a caseload was striking. In contrast, all of the other facets had been open to change.

Table 8-2: Facets of Caseload work and primary responsibility

	Scenario 1	Scenario 2	Scenario 3
Waiting lists	Manager	Hub	Service
Triage	Manager	Hub	Service
Assessment	Therapist	Hub (any 2 therapists at joint clinic)	Therapist
Intervention (individual)	Therapist	Therapist	Therapist
Intervention (group)	Division	Hub (any 2 therapists)	Service
Building capacity	Therapist with designated universal role	Hub	Service

I will now explore the implications of therapist, manager, hub or service having responsibility for Caseload work. I will give most detail about the hub model as it was particularly enabling for SSD practice change.

8.5.1 Caseload work: therapist responsibility

Even if they shared a filing cabinet, participants had their own clinical caseloads. [S4] had transferred a child with SSD to a more experienced

colleague, so "now she's HERS.. she's not MINE,you know? So it's like.. you DO just hand over the entire case." Both [S4] and [B3] had transferred a child with SSD to another therapist due to lack of progress. While they enquired after the child, they did not ask what the receiving therapist had done.

An exception to solo responsibility, which [S4] likened to "stepping into someone else's caseload", was "parachuting in" to do review or assessment clinics. This made [S4] feel productive, but without ownership:

> you're sort of conveyor belting them through sort of thing em.. to lighten the load of.. other people.. eh rather than.. building your own caseload and.. you know, really doing 'therapy'

Having responsibility for a caseload was a mark of autonomy. [B15] pointed out that community speech and language therapists had a "HUGE AMOUNT of autonomy (pause). HUGE. When you compare.. our role to say a TEACHER". As [C5] observed, autonomy became more apparent when it was challenged:

> we've been a bit LESS autonomous with our caseloads... because we're all having to MEET with our team lead. (pause) To go through the caseloads, using a prioritisation tool. (pause) Case by case.. child by child (laughs) Takes quite a long time. Em.. so that we're all doing.. the same kind of thing..

Although autonomy bred self-reliance, [B5] painted a bleak historical picture of "SOLITARY" and "ISOLATED working" because therapists were spread out geographically, rarely got together, and ran with their own patch, caseload and manager. [S11] worried about a colleague with "a very large caseload" and wondered "how on EARTH are you managing that, ALL on your own?"

Working very autonomously with caseloads had implications for Service consistency, as [B2] recalled with dissatisfaction:

> when the phone went and someone was on maternity leave.. [[mhm]] you just kind of had to say 'well we're not.. providing a SERVICE at that time'

8.5.2 Caseload work: manager responsibility

Managers took temporary responsibility for facets of caseload work in response to a particular problem. [B10] took on Triage "for two YEARS" due to "a HOST of things" including a sharp rise in the local population. [C7] took responsibility

for Triage partly because "it's a WEE bit of a.. jump of MIND SET", and partly "because we were short-staffed and nobody had TIME. I didn't want to add any extra pressure on anyone."

[C5]'s manager temporarily dealt with waiting lists:

> to PROTECT our caseloads.. because.. {when we're} getting more and more children coming IN.. and.. understaffed with maternity leave and people em.. changing roles... and em.. what happens is you-you spend less TIME.. with the kids ON your caseload. So they sit on there for LONGER.

However, this made [C1] feel less in "control" of "my WORKLOAD and my CASELOAD" as "I can only deal with it when they come IN. You know, [[yes]] whether it comes in in dribs and drabs, or it comes in as five".

8.5.3 Caseload work: hub responsibility

After a redesign, [Blaeshire] shifted to a hub model with groups of mixed grade therapists in a geographical area sharing work more efficiently across caseloads. [B7] explained:

> So: they might say, 'so we've got, I don't know, two hundred kids in this area.. and you know, you're seeing fifty of them and I'm seeing fifty or whatever.. and.. we seem to have an awful lot of pre-school stammerers just now.. or whatever'. So they discuss workload, caseload issues em.. including, you know, 'we're repeatedly getting poor referrals from such-and-such a.. school. So we need to do, who's gonna do the in-service training there?' So it IS beyond caseload.

This distribution of work was variously referred to as a 'collapsed', 'corporate' or 'shared' caseload. Hubs had considerable freedom to manage the workload to suit their local context. Even the joint assessment clinics which all involved two therapists were diverse (e.g. a half day every week / a regular assessment clinic week).

For all hubs, the extent to which caseload work *should* be collapsed was an ongoing project, and what was meant by collapsed - or *not* collapsed - varied. Following the assessment clinic, [B6]'s hub would see "WHO'S got the SPACE and.. em.. the cases are shared out." While they tried to do it for a geographical or other sensible reason such as "actually I'm seeing.. someone ELSE in that class", their emphasis was on workload equity. Reflecting on the characteristics

of her hub, [B15] said they were "TRYING to.. look at things like.. triaging em… JOINTLY or.. you know, having more of an overview of who's coming in". All carried generalist caseloads but tended to do "more flexible working" through sharing or swapping cases depending on clinical interests.

Prior to having a collapsed caseload, [B13]'s hub had members "in charge" of particular schools. Now it was an "OPEN process" in schools, and "working more kinda openly in clinic too?" [B20] agreed that while each therapist had their own caseload they now had "a BETTER knowledge OF each other's CASELOADS", so they could "draw.. parallels" between children and learn "from each other's SUCCESSES and from each other's CHALLENGES". [B14] reflected that Care Aims had "helped us STREAMLINE our caseloads.. and made it EASIER for having a.. SHARED caseload, really. (pause)".

In the hub that identified *least* with the idea of a collapsed caseload, each therapist had "a lot of autonomy"[36] and responsibility for caseloads and schools. Geography and limited clinic space meant this was more "practical", and it was "EASIER as a therapist to ha- to build relationships in a school that you're going in more consistently". They associated a collapsed caseload with being clinic based. They nevertheless used meetings to "CHECK IN with each other" to make sure "no-one's getting too overloaded". This meant they could "switch things around a little bit just to make sure.. [[mhm]] it's as equitable as (overlapping) we can make it".

The hub that identified *most* with the idea of a collapsed caseload had originally "basically got ON with stuff.. yourself" because once the joint assessment clinic was finished "you would be left with INDIVIDUAL children!" They now had more of a team "ethos" and were trying to secure clinic accommodation to make the service more equitable in areas of disadvantage. They had a "shared caseload to a degree.. seeing where there's availability", but also brought "kids together for, particularly for FOUNDATION-type work to do with speech sound.. issues". They ran parent groups to follow on from assessment clinics, which "really takes the pressure off us as individual therapists" because it gave flexibility to manage the distribution of cases and offer early preventative advice. In

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[36] To protect anonymity, quotes not attributed in this or the following paragraph

addition, they had invested heavily in building capacity and evaluating the impact of different models.

This variation in implementation of a collapsed caseload in [Blaeshire] was possible because managers recognised that hubs and their local contexts were different, so the detail of their decision-making would also be different. [B10] explained:

> we've always had the desire to move towards more of a collapsed caseload?.. Although there's also a DANGER.. in that situation that people em.. don't accept full responsibility? So we've been very CAREFUL round about that as well. So people RUN with their own caseloads.. BUT.. there is an AWARENESS overall of how BUSY individuals are withIN that.. environment and.. there are.. discussions about who has capacity to take cases ON.. and who would be BEST PLACED to do that piece of work. And that's allowed that.. conver- these kind of conversations and decisions to develop within the [HUBS] and go out and do building capacity work IN SCHOOLS, AS A TEAM.. and to share skills in that.. area..

All participating NHS services were working in - or towards - a hub model. While elements of a collapsed caseload were evident, the terminology was not. In [Staneshire], [S13]'s hub used "team meetings to say 'so how is that one doing?'.. have we moved him down the chart, and if we haven't.. why?'' [S3]'s hub had started to "talk about clinical CASES" and "share decision-making". [S1] shared a clinic base with a colleague, so they tended to "problem-solve with each other" and had "a handle on each other's caseloads". She referred to this as "a bit of a shared caseload". In [Clootshire], one hub were deliberately in regular contact. [C8] emphasised it "not as a SOCIAL bit, I mean, which is NICE, but it's MORE than that", and [C2] found it generated "lots of solutions". Members of [C6]'s hub were "quite autonomous" but with a "sense of a team round about you". In practice, this meant:

> we would run our own CASELOADS.. em.. but with LOTS of opportunity for... discussing that between ourselves... or possibly passing a case OVER.. or.. looking together at GROUPS with children.. from ANYBODY'S caseload..

Some [Clootshire] and [Staneshire] hubs had less distribution of caseload work. Even if they identified as a supportive group emotionally, it was up to therapists to manage their caseload work individually as best they could. This was

expressed indirectly. [C5] was able to have a little flexibility with Dosage because "we prioritise our OWN caseloads". [S5] said "we all do our OWN… type of thing", while [S9] qualified a remark about her own experience with "I don't KNOW what other people's caseloads are like".

8.5.4 Caseload work: service responsibility

Services took responsibility for caseload work when standardisation was seen as an equitable solution to waiting lists, high caseloads and cuts in funding. Although "I'm not prepared to DO that", [C4] felt:

> some people probably panic. D'you know, if I- if they'd said 'right.. you've got a caseload of six hundred and now this little team is gonna have a caseload of one thousand TWO hundred... I can see, and I have worked in departments before, where they said, 'right! we just won't DO THIS. We won't do THAT. People have to come to US. Schools will only get one visit every FOUR weeks instead of one visit every TWO weeks'

Service responsibility could include standardised pathways. In [Staneshire], [S7] and colleagues were evaluating if it was most "efficient" to be "categorising" children for different types of "therapeutic input". Therapists were piloting workshops for parents of children with SSD beyond those on their own caseload (9.3.4.1).

There was considerable angst among [Blaeshire] participants about the idea of standardised intervention pathways. When [B2] received a query from someone in another service about care pathways for children with SSD, it "immediately kinda struck me that.. our management.. DON'T expect us to operate in that way". Referring to a service that had very "rigid" therapy blocks, [B12] felt "lucky" to have more autonomy.

[B20] knew of a service where children with "ANY kind of speech sound disorder" were placed in a rolling series of oromotor, placement and voicing groups. She was concerned firstly that this was not evidence based, and secondly that it took away "ANY kind of" clinical decision-making and ownership. [B13] agreed that "if all that sort of stuff EXISTS.. you don't then THINK.. CAREFULLY about each family", but in terms of pre-defined categories. This was inappropriate as "actually… every single child is very UNIQUE".

The strength of local feeling against pathways was felt by a [Blaeshire] hub who had invested in group intervention processes. [B14] was at pains to counter perceptions amongst colleagues that these were "a kind of 'FACTORY' almost":

> it took.. a LOT of.. time and effort for us to (pause) CONVINCE people that actually... if a child doesn't.. need this, they don't go ON it.. if a parent doesn't want to sit in a group with other parents, they (overlapping) get this INDIVIDUALLY

Concern about standardised intervention pathways therefore reflected not just a concern to treat every child as an individual, but to defend the value of devolved clinical decision-making, which [Blaeshire] had worked hard to develop. [B11] explained:

> I feel like there's still a MASSIVE em... PUSH for em... GOOD DECISION-making here. (pause) [[right]] And nothing should.. em.. get in the WAY of that. (pause) And I think that that still happens even when people are... panicking about numbers.. cos it HAPPENS, you know, sometimes.. and you could be DOING the best you CAN, you could be using Care Aims, you could be TRIAGING, you could be setting up GROUPS and your numbers are still HIGH for whatever REASON... em... but I think there's a r-real kind of importance placed on.. making sure your decisions are.. are GOOD. And people are CHALLENGING your decision-making all the time. (pause) As well. (pause) Which is quite nice. (pause)

8.6 From Caseload to Service

Although clinical caseloads were made up of individual candidates, they were also a whole. Pressures on NHS services meant the work of and around a caseload was a significant concern. Four Caseload dimensions (size, composition, time on caseload and distribution of work around a caseload) were addressed in different ways, creating key differences in the Caseload aspect of the practice context. These differences helped to explain different trajectories of practice change.

As clinical caseloads belonged to services as well as to therapists, the Caseload aspect of the practice context was heavily influenced by the Service aspect. In the following chapter, I will examine the Service aspect in more detail.

9 Service aspect of the practice context

9.1 What a Service is in relation to practice change

In exploring the Intervention, Candidacy and Caseload aspects of the practice context, the influential role of the Service aspect has repeatedly stood out. This chapter therefore assesses in more detail the contribution of the Service to the trajectory of practice change for SSD at the specialist level[37].

Three NHS services and individuals in private practice participated, and similarities and differences within and across these groups helped to explain SSD practice changes. The three NHS services are pseudonymised as [Blaeshire], [Staneshire] and [Clootshire]. Although operational divisions of [Clootshire] worked closely at a strategic level and faced similar pressures, differences in how they were tackling SSD had consequences for the types of practice change they helped generate. Where this difference is relevant, [Clootshire] is reported as two service contexts, [Clootshire A] and [Clootshire B]. Conversely, while the three individuals in private practice operated separately from each other, their collective experiences of practice change were explanatory in comparison to the NHS services as a whole. Private practice is therefore reported as one service context.

Four dimensions of the Service aspect were most relevant for the trajectory of practice change: how the service was organised and structured, what, how and why the service had invested in SSD over time, expectations around the general direction of practice, and types of SSD intervention that were or were not routinely possible for therapists in that service to do (Figure 9-1). In this chapter I will explore each of these in relation to each service context (hereafter referred to as 'service').

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[37] Speech and language therapy can be provided at three levels: universal (population), targeted (at risk) and specialist (caseload). Any of these levels can be provided by a generalist or a specialist therapist. A community generalist therapist's caseload comprises children (and sometimes adults) in a geographical area who have a range of speech, language and communication needs. This means intervention for SSD at a *specialist* level is usually provided by community *generalist* therapists.

Figure 9-1: Service dimensions
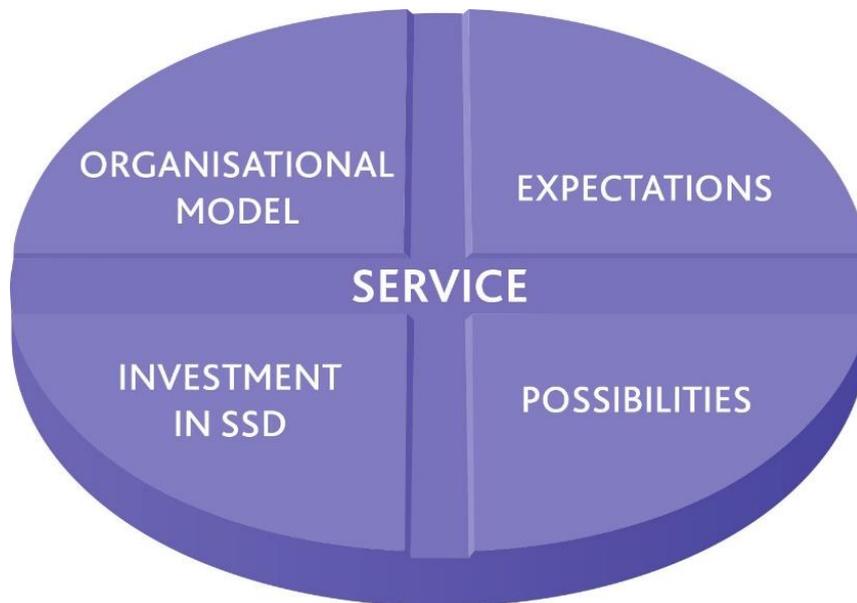
9.2 Dimension: organisational model

9.2.1 Structure of private practice

Three individual participants joined the study as private practitioners, meaning they had direct contracts for their services with families, and determined their own hours, geographical patch and way of working. All were also experienced NHS therapists, with a career history of combining and / or alternating these roles. One only saw children with SSD for intervention, while the others had more generalist caseloads.

9.2.2 Structure of NHS services

From conception of the study, I mapped out similarities and differences between the NHS services that were potentially relevant to SSD practice change. Apart from geography and snippets of historical knowledge and gossip, I knew little initially other than that [Blaeshire] had done specific work on SSD, [Staneshire] had supported clinical effectiveness projects, and [Clootshire] had used technology to encourage a more social approach to learning.

The basic structure of community paediatric speech and language therapy for all three was shaped by geography, with areas split into operational divisions

made up of locality hubs. Hubs comprised small groups of therapists with a mix of bands, often including a support worker. The similarity of this set-up was not obvious; for example, the interplay with specialist teams was confusing, and in two services organisational structures were in flux.

Table 9-1 shows other key similarities and differences in how the NHS services were structured. Generic terms are used where possible to make comparison easier, and highly identifiable information omitted to preserve anonymity.

Table 9-1: NHS service structures

	[Blaeshire]	[Clootshire]	[Staneshire]
Professional leadership	Professional leads, hub team leads, planning group	Divisional leads (also operate as care group leads and meet as a planning group)	Professional lead, divisional leads (making up a planning group), some hub team leads
Geographical spread[38]	From Other Urban Area to Accessible Rural	From Other Urban Area to Remote Rural	From Large Urban Area to Remote Rural
Main staffing issue	Maternity leave	Vacancies Boom and bust / long time to fill posts	Downward pressure on banding; some loss of posts
Spectrum of generalist / specialist responsibility	All paediatric community therapists are highly generalist	Most community therapists are paediatric mainstream but some mixed posts in remoter areas	Paediatric only, becoming more generalist, but historical variation in hierarchies in different divisions
Approaches to practice development at service level	Joint assessment Peer facilitation Journal Clubs Hub projects SSD initiative	Staff meetings used (e.g. peer trios) Shadowing	Working groups Clinical networks Band 5 projects

Overall, [Blaeshire] had structural reliability relative to the other services. At the time of fieldwork, the work of the [Blaeshire] service (including a specific SSD initiative) was implemented through established structures. These included a

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[38] Based on Scottish Government Urban/Rural 6 Fold Classification, 2013-2014: Large Urban Areas, Other Urban Areas, Accessible Small Towns, Remote Small Towns, Accessible Rural, Remote Rural

stable management team that had, over many years, "fought tooth and nail to stay together as a [Blaeshire]-wide integrated, fully integrated service.. you know, from birth.. to death" [B10]. Over time, they had gradually shaped the community paediatric service into a model where hubs with team leaders took responsibility for implementing service expectations to suit the local context:

> we-we ARE given a fair amount of FREEDOM [[mhm]] in comparison to other services [[mm]] TO.. use it but.. it's used.. WITHIN the PARAMETERS that they've.. SET. And they ALWAYS work like that [[mhm]] you know when we're making our.. TARGETS for what we WORK ON.. they give us.. the BIG PICTURE of what they're expecting us to do, be that the evidence base, be that CAPACITY building.. but then it's down to us about how we.. implement and DELIVER that so I think.. the STRUCTURE in [[mhm]] which we work gives us the FREEDOM.. to actually DEVELOP those things BECAUSE... systems aren't enforced upon us [B2]

[Blaeshire]'s stable structure included peer facilitation, introduced well over a decade before to sustain Care Aims. Mixed groups of therapists (different client groups, different divisions, different levels of experience) discussed their decision-making, each led by one trained in facilitation. While the detail had moved on over the years, the underlying purpose of opening up decision-making so it could be supported or challenged remained the same.

Organisational changes in [Clootshire] and [Staneshire] were more recent, with their energy directed towards making reconfigured structures work. [Clootshire] had emerged from several years of "MESSY" uncertainty where "we didn't know what was happening" [C7] with a reorganisation of leadership, including redistribution of resources and responsibilities. For staff, this was "a PROCESS we're going through AT the MOMENT… so it's something you're in the MIDDLE of rather than looking BACK on", meaning that "we're adjusting to changes in.. what responsibilities we have.. who's managing what.. where.." [C6].

[Staneshire] was using cross-service mixed-band working groups to bring together divisions which were "very different ANIMALS". Having operated relatively independently, "the way they work together and the way they support each other.. is quite different". The aim at a service level was to recognise "there is GOOD IN ALL.. em and it's actually HARNESSING… the BEST.. and NOT putting the other ones' noses out of joint" [S7].

The relevance of service geography to SSD practice change was not as strong as I had anticipated, but two differences helped explain why [Blaeshire]'s structure and stability were favourable to a service-wide SSD initiative. Firstly, [Clootshire]'s relative remoteness was connected to repeated problems filling vacancies that [Blaeshire] had not had to deal with. Secondly, in [Staneshire], the effects of a historical concentration of specialist posts in a Large Urban Area were still being felt, and the service was moving to a more equitable structure for staff and clients. In contrast, [Blaeshire]'s leadership had shaped the service so that all community paediatric staff had been highly generalist for a number of years. The developing hub model in [Staneshire] bore similarities to the established [Blaeshire] model, and had a similar rationale of increasing generalism. This raised the question of whether it might provide a necessary - albeit insufficient - foundation for the practice changes seen in [Blaeshire].

9.3 Dimension: investment in SSD

Services faced an array of competing options and demands for their limited resources. They therefore differed in whether and how they had invested in SSD practice change at the specialist level.

9.3.1 [Blaeshire]'s investment

[Blaeshire] was coming to the end of a sustained SSD initiative "to move a whole staff group" [B7] to manage intervention for children with SSD more effectively and efficiently. Six years on, there was consensus that the programme had achieved its objectives:

> I THINK we've reached critical mass? (pause) Now? Em and I think it would.. ((puts on confidential tone)) I'm not saying that ALL of the therapists' understanding is at the same level or use it.. in the same WAY em but I THINK.. for the MOST part (pause) there would be a MUCH MUCH eh DEEPER analysis of a child with a-a speech sound system.. difficulty.. coming through.. and you would see a much much higher level of differentiation.. and you hear the different approaches being discussed.. between staff.. 'I've tried THIS, that worked really WELL'.. 'I think it worked because.. but I'm not shifting THIS element of the difficulty.. so what I was thinking was..' em.. rather than just saying ((puts on robotic voice)) 'I will do.. Colour Coding from now until.. because that's what I know and that's what I've got in my toolbox ((voice ends)) and that's what I pull out every time'... [B10]

Participants also referred to service-led pieces of SSD work that had begun around six years before this initiative. Table 9-2 sets out an approximate timeline, with the SSD initiative components shaded.

Table 9-2: Timeline of [Blaeshire] SSD investment

Years	Events
1-6	At least two [Blaeshire] staff ask at various times for SSD training; leadership team aware of some clinicians' discomfort that children with severe SSD can be on caseloads for a long time
1	Short-life phonology working group (initiated by a therapist with permission from the leadership team) maps intervention practice on a spreadsheet
1-6	Therapists from specialist language provision lead work on Colour Coding, visual feedback, link to literacy
1-2?	Cross-service recommendation to use the CLEAR assessment
2	Consultant speech and language therapist post created
4-?8	Hub-based Journal Clubs set up with support for critical appraisal (some therapists choose SSD papers)
6	Member of staff self-funds two day Caroline Bowen training, and recommends service takes this forward
6	Presentation on the DEAP at a child language event attended by a group of [Blaeshire] therapists (including the Consultant)
6	Leadership team acts on recommendation for Caroline Bowen course. Selects three therapists, and asks them to attend two day course and prepare training for staff
6-7	Leadership team agrees to give the three trainers time to try out the new ideas in their own practice before passing on to other staff
6-8	Consultant therapist supports one trainer with implementation of a new approach, and a before-and-after comparison of decision-making
7?	One trainer seeks and receives permission to modify Stimulability character names to suit local context
7	Three trainers run mandatory Workshop 1 for all community paediatric staff and managers (based on lightbulb moments – Multiple Oppositions, Maximal Oppositions, Empty Set, Stimulability) On recommendation of a trainer, leadership team provides two SSD textbooks for every clinic base Trainers use questionnaire for feedback
7-11	Trainers available for consultation (one in particular receives a number of phone calls after Workshop 1)
8	Leadership team agrees with team leaders a range of hub projects to look at evidence base with support of librarian; one hub is given phonology (a conclusion is that ages and stages are not an appropriate framework for a clinical population that needs intervention rather than advice / home pack)

9?	Two trainers take SSD initiative forward. Send questionnaire to staff in preparation for Workshop 2 – conclude not enough understanding of terminology, or use of in-depth assessment for it to go ahead at this point
9	Trainers change planned workshop to group sessions with a reading list and terminology task. Mandatory, but hubs or other self-selecting groups choose the detail of how and when this is done
9-11	Hubs / team leaders gradually take more responsibility for keeping SSD initiative 'live'
10	Trainers run mandatory Workshop 2 for all community paediatric staff and managers (assessment; terminology quiz; practical activities e.g. DEAPs to score)
11	Trainers organise mandatory Workshop 3 for all community paediatric staff (target selection and case examples), intended as last formal event of SSD initiative
7-11	Leadership team encourage and expect staff to use new approaches, to advance their knowledge in protected learning time, and to pass on their learning to students on placement with the service. They also ask about it, e.g. in PDP[39] sessions, and encourage writing of case studies

9.3.1.1 [Blaeshire]: investment by leaders

Time and again participants credited the [Blaeshire] leadership team with giving the SSD initiative an extraordinary "push" [B18]. Even though managers were already perceived as clear with expectations and strong on providing relevant training, service support for this initiative seemed more multi-dimensional. Consider this exchange:

> [B1]
>
> but this.. this has really been pushed, though, Caroline Bowen [[yeah]] because like everybody did [names a language intervention].. but I don't think (laughs) [[yeah]] very many of us have used [language intervention].. that much.. as yet [[right]].. it's just something that was PUSHED within the department and then you had.. you were FOLLOWED UP and you were ASKED about it in your.. your sort of eh.. [[yeah]] [[PDP]] PDP and.. you know peer supervision and.. the [hubs] it was always.. quite pushed so sometimes you NEED that little bit of.. a push to keep it going as well.. em.. because I know.. like.. cos nobody.. nobody ELSE has done [language intervention] I haven't gone and READ anything and I.. at the TIME I thought.. 'that would be really USEFUL I could [[mm]] probably use it with some people' but.. there hasn't been the same PUSH with that.. as there was with.. Caroline Bowen? [[mhm]] so it sort of.. I suppose there's..

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[39] Personal Development Planning

you can't do too many things at ONCE either.. [[mhm]] so eh.. that was just one change and I think it has WORKED [[mhm]] {given us a} PUSH

[B12]

cos it came almost like.. a bit of.. ALMOST like a bit of ring-fenced time we've had for it because there's a push cos like you I LOVED the [language intervention] stuff.. but I haven't had TIME to go BACK [[NO]] and SIT and look at it PROPERLY.. in order to IMPLEMENT it [[yeah]] and it's not been something we've.. taken forward.. [[mm]] in all these other areas that we did with the Caroline Bowen. (long pause) [[there's-]] I think a lot of it came out of our Journal Clubs as well, didn't it [[yeah]] cos we were all looking at EVIDENCE in lots of different areas and because that bit.. came out of.. [[mhm]] the Journal Clubs I suppose, and it all kinda TIED IN at the same TIME didn't it? (long pause)

Whilst knowing the leadership team had pushed the SSD initiative, participants were not sure why. The trainers had not requested SSD training, and were unaware why they had been selected ("to be honest I was like 'Caroline BOWEN?' you know, 'Who's Caroline BOWEN?'" [B8]). They were conscious of the investment and their obligation to feed back to staff, and two felt an extra responsibility as team leaders. However, the scale and tenacity of their effort and the engagement of the leadership team demanded further explanation.

[Blaeshire]'s leadership team acted when a "highly respected" [B10] clinician ("she READS" [B7]) returned from a Caroline Bowen course and made the case. The three therapists selected to go on behalf of the service also returned saying "this was HUGE, it was GROUND BREAKING" and [Blaeshire] needed to "stop the BUS and GET OFF.. and look at what we were doing" [S10].

The leadership team were receptive because almost all were experienced in working with children with SSD, and shared a commitment to developing the profession's linguistic expertise:

our speciality should be around the LANGUAGE things? Because nobody, you know, we've got, there's linguistics and there are linguists and there's psychologists and so on. But we're the ONLY ones that kind of.. bridge that gap.. between trying to understand.. the sort of, neuroscience, or whatever OF language, and actually do something practical about it? And that's, THAT'S.. if you get a therapist who is GOOD at that? That's like a GEM.. really. It's so.. it's so.. RARE. Because other people are maybe more academic or, or just wanting to go cookbooky but.. I think for a lot of therapists (pause) it-it's quite HARD [B7]

Moreover, [B10] perceived the complexity approaches to SSD as a "sea change" that marked where a "genuine change in THINKING happened". She compared it to practice changes with other client groups, which had either developed from a previous sea change, or involved "a CULTURAL.. shift" around risk and duty of care rather than the internal workings of an intervention. Indeed, throughout [Blaeshire] interviews, the fracture between old and new repeatedly stood out:

> even though I'd spent YEARS doing phonology therapy.. but this.. to ME.. it was like it wasn't even phonology.. it was like totally something DIFFERENT… [B3]

9.3.1.2 [Blaeshire]: investing in students

This sense of a sea change meant staff now felt a responsibility to pass their learning on to students. Implementation set up expectations that placement students in [Blaeshire] would have the opportunity to see and use non-traditional SSD interventions.

Students did not appear to be seeing these in use elsewhere or learning about them at university. [B2] therefore saw it as a hub responsibility to be "very explicit" with students about what they needed to read in preparation for a placement, to put aside time for conversation and reflection on these interventions, and to make sure the student had opportunities to use them. Without wanting "to sound too.. EVANGELICAL" about it:

> I think.. for ME that's probably one of the BIGGEST shifts that yes we've got to help.. the STAFF move on but.. we have a big responsibility with the students to.. to kind of REALLY change their thinking.. to get them.. ON the right page for starting practice too.

9.3.1.3 [Blaeshire]: investing in learning

The people who attended Caroline Bowen's course experienced the diversity and amount of content as evidence that practice had to change. However, the volume of "information THROWN at us" [B8] meant they had to be selective in what they tried themselves and chose to pass on to staff. All noted 'lightbulb moments' - which were not necessarily the same - and spent time making sense of the information through bullet pointed notes and discussion.

In retrospect, they felt "really OVERWHELMED" [B3], but fortunate to hear from Caroline Bowen in person. Although her lecture style was "VERY much ONE WAY (pause)" rather than interactive with "NO opportunity for.. case discussion" [B15], she covered a lot of ground, included useful anecdotes from practice, and backed it up with a comprehensive manual.

Before they could help their colleagues, the trainers needed time to try out the new interventions and "SEE the GAINS" [B8] for themselves as suitable children came up. The leadership team supported this plan, recognising that in cascading their learning the trainers would be "EXPOSING" and "making themselves VULNERABLE really" [B10]. Nevertheless, the time involved in getting to grips with the interventions was substantial:

> I was thinking.. 'if I get any more disordered kids.. like I'll no have TIME to SEE them! (laughs) cos like THESE are taking UP.. AGES', they DEFINITELY took AGES and AGES.. d'you know I can remember spending a WHOLE DAY like with the girl's file.. like doing the results then going to meet [consultant therapist], now I KNOW that was probably cos of my CONFIDENCE in doing it and stuff.. and then coming BACK and.. because in the books, d'you know, it was all the <t> and <d> stuff and she WASN'T doing that, so you had to be coming up with all your sets and stuff yourself and finding words that were proper and like.. that whole thing I could remember thinking 'actually..' at POINTS I was nearly thinking 'this is too MUCH, I'm just gonnae have to abandon this' [B3]

9.3.1.4 [Blaeshire]: investing in facilitation

The trainers who were team leaders took the initiative forward after Workshop 1, and gradually recognised that no aspect would be speedy. Although "feeling BAD" about the process "DRAGGING on" [B8], individuals and hubs were very different in how quickly they felt able to bring the new interventions into their practice, in the opportunities they had to do so, and in what happened when they did.

In recognition of this, and in line with their understanding of [Blaeshire]'s culture and their responsibilities as hub team leaders, the trainers' focus shifted from *sharing* information to *facilitation*:

> we are.. continually having to think about... what's the best way to influence... change in our.. in the TEAM.. em... and think of it from that point of VIEW and think about activities that really make SENSE or.. examples.. case studies that will get the BUY IN that.. that WE'RE saying..

you need.. to give you the em motivation to devote the time to it and just try it OUT... em.. so yeah from THAT point of view it's.. made us think.. quite a LOT about it and realise the TIME it takes... for a.. not for everybody but MOST people need... a lot of time and a lot of em... not MISTAKES but.. UN.. UNsuccessful experiences... along with the successful ones before they make the.. changes for GOOD.. [B8]

Facilitation included encouraging staff to refer back to the textbooks before consulting them or colleagues, and while discussing the interventions. It also involved understanding where people were struggling and needing more detail or support. The trainers asked for feedback after each session and before planning the next, and used this to inform decisions about format and content. The focus of Workshop 2, for example, followed recognition that people were "still em… taking SHORTCUTS in relation to assessment" [B8]. These shortcuts manifested in two ways. Some therapists made assumptions during assessment that led to precipitate selection of Approach and Targets. Others continued to use the CLEAR assessment because it was quick, without necessarily recognising it was structured to support traditional intervention.

Facilitation also involved a gradual transfer of responsibility from the trainers to hubs to keep up the momentum. The favourable nature of the [Blaeshire] structure was apparent when [B16] discussed three levels of implementation implications for the SSD initiative: the service, the hub and the individual therapist. The service level was about the ideas, the hub level about the processes, and the individual level was dependent on the cases that came up.

Part of hubs taking responsibility was the result of luck rather than design, when Workshop 2 was postponed and the trainers instead gave the hubs a reading list and activities to do in ways that best suited them. This opened therapists' eyes to the challenges of intervention fidelity. One hub arranged structured opportunities to discuss book chapters, and [B20] was surprised at the extent to which "equally" educated people could read the same thing, yet understand and remember it slightly differently. This made her query the value of *learning* in isolation. In another hub, [B1] linked the problem to *practising* in isolation:

> when we READ the BOOK or.. an ASSESSMENT.. I might interpret it different from the way.. [B9] has interpreted it [[mhm]].. and.. I don't think.. because you never WATCH really each other's practice.. you.. you don't know.. if you're doing the SAME THING? or.. if you're doing the RIGHT

THING?.. but it's just the way.. well actually when I was sitting next to [Dorothy], [Dorothy] and I were doing.. totally.. (laughter) DIFFERENT.. things! And I think we were both doing different things from [B9]!! (laughter)..

9.3.1.5 [Blaeshire]: investing in the right thing

Participants referred to different hubs (including their own) as if they had personalities, contributing to a sense that a competitive edge played a part in the SSD initiative. Across the service, the new ideas had been met with fear, resistance, uncertainty and initial incomprehension as well as with hope, imagination and perseverance. Everyone had found it challenging to put the new interventions into practice, and efforts had met with mixed experiences of success. In spite of this, all had engaged to some extent with the SSD initiative and made at least some changes to their practice. The question was, why?

The most enthusiastic hub was observed to be driven by believing it was the right thing to do:

> they found it difficult, but there was no QUESTION about whether they were gonna DO it or not, they were DOING it... [B11]

A strong thread running through all [Blaeshire] contributions was that the right thing to do was connected to what action they could take to bring about the biggest change for children in the shortest amount of time. [B16]'s reaction to the SSD initiative, for example, had been:

> oh great, here's some approaches for these children that you think 'OH MY GOD!!!' when you meet them… 'you've got a WHOPPING phonological disorder and.. what can we do to HELP you?' and.. and also that.. actually maybe we could sort this QUICKER now? For you? Which em.. practically is great for our.. throughput and numbers and all this kinda stuff but for the individual child it's fantastic, I mean the quicker they can.. their speech difficulties can resolve the better that is for THEM, for their CONFIDENCE, for you know… and.. you know.. nobody WANTS to come speech therapy EVERY WEEK (laughter) FOR YEARS do they?!

9.3.2 [Clootshire A]'s investment

Following a recent change in service structure and leadership, [Clootshire A] were focused on planning and working towards the kind of service they wanted to be. This was possible because, rather than continue to "cut things away" as

had happened over the years, they decided "let's just STOP. And THINK about what we're doing. And how we use the resource.. we've got" [C4].

Three areas of investment were intended to impact on children with SSD. The first aimed to bolster input at the universal level, and the second to distribute responsibility across education and speech and language therapy. The third part of the plan was to use the space created at the specialist level to hone and strengthen skills for work only speech and language therapists could do.

9.3.2.1 [Clootshire A]: investing at the universal level

A "PUSH on literacy" across [Clootshire] and from the Scottish Government meant that "the ownership.. of.. phonological awareness… is changing" [C4], and therapists were involved in literacy working groups and resource development. The longer-term intention was that *individual* therapists would no longer need to devote time to advising *individual* teachers on this level of support for children.

9.3.2.2 [Clootshire A]: investing in distributing responsibility

Meetings had been held with head teachers across [Clootshire A] to agree the best use of available resources for children, including those with milder SSD. The driving questions were around what needed to be done, who was best placed to do it, and what contribution each party could make. [C4] perceived these meetings as "a good place.. for.. presenting EVIDENCE. About what works and what DOESN'T work" [C4]. The negotiations had also led to trials of local in-service training, with the topic determined by the teachers.

9.3.2.3 [Clootshire A]: investing in the specialist level

[Clootshire A] participants believed that, while responsibility for certain communication difficulties was "more.. readily.. SHARED.. with somebody at nursery or in SCHOOL em.. cos they would be working in that type of area as well", SSD was "a much more SPECIFIC difficulty.. that needs.. more SPECIFIC intervention" [C6] from a therapist. [C4] additionally felt that having "a VARIETY of approaches" for SSD - and the reasoning to change or modify them - was not only essential, but one reason this work was "so hugely SKILLED".

Permission to "STAND BACK" from everyday practice had been experienced as "a RELIEF" for staff who had previously recognised that things needed to change but been unable to "get it going" because "we got caught up with other things" [C8]. Having taken time to plan, think through and agree implementation decisions together, one hub had chosen to be more flexible with logistical aspects of intervention (Dosage, Format, Place) and offer bursts of greater intensity of intervention for children with more severe SSD:

> so the poor child's getting it from ALL ways!.. but.. we're ALL saying the same- I think that's what the MAIN thing is, we seem to now ALL be saying the same THING.. [[yeah]] at the same time.. [[mm]].. [[AVRIL mhm]].. which.. which has ONLY come about because we've put everything else in place.. [[mhm]].. that we've FREED UP that time.. [[mhm]].. [C2]

Being "HU:GELY frustrated" when intervention didn't work for children with SSD, [C4] was determined to focus the service on clinical effectiveness, and to hear a variety of interventions being discussed and passed on to new graduates. Staff understood that, following a period of agreeing and adjusting to new processes, discussion "might come DOWN to intervention as we work THROUGH it" [C6].

[C4]'s mention of a non-traditional approach to SSD intervention, and reference to Caroline Bowen as having "a fairly universal.. respect", suggested local awareness of additional options for intervention. However, efforts to encourage therapists to discuss cases had faltered as, although they were "CONFIDENT" practitioners, they were "quite apprehensive and cautious. About exposing what they do". As a consequence, [C4] planned more conversations about SSD intervention over the longer term:

> what DOESN'T happen.. and what.. is what I'm working on and I've spoken to YOU about.. is.. having that DISCUSSION, that.. SOCIAL use of the knowledge so that you TEASE it out, and you make it your OWN. Eh.. so you don't just take the evidence and try and apply it. You think 'okay.. THIS bit of research.. or this.. you know, there's this body of thinking about that.. em... I've tried it or.. you know, this isn't working'. And it's not, it's not looking for somebody else's IDEAS.. it's about that TEASING, teasing out that you do WITH somebody else. You can DO it on your OWN. But it's not NEARLY as effective as doing it with.. somebody else.

9.3.3 [Clootshire B]'s investment

To help explain why some services invested in SSD practice change at a specialist level, it was important to understand why [Clootshire B] did *not*. Firstly, [Clootshire B]'s priority was to redistribute resources *away* from the specialist level towards universal services, with the aim of supporting speech and language development more effectively at a population level. Secondly, there was no obvious driver or demand for investment in the specialist level.

9.3.3.1 [Clootshire B]: investing in universal services

Within the last five years, all [Clootshire B] therapists had been encouraged to do more training and universal level work, and to use their specialist contacts as an opportunity for broader influence.

Recently, [Clootshire] accelerated this by disinvesting in specialist language provision to reinvest in a post supporting universal services. This redistribution aimed to boost children's speech and language at a population level through in-service training for teachers and strategic partnerships with other professions such as teaching, educational psychology and occupational therapy. Although focused on language rather than speech development, knock-on effects were anticipated. Some schools, for example, had chosen phonological awareness as their focus for an improvement programme to raise attainment.

An ongoing programme around literacy pre-dated this post. It was producing "EARLY developmental continuums" [C5], including phonological awareness, and had given therapists access to high quality phonological awareness Material.

9.3.3.2 Why [Clootshire B] was not investing in the specialist level

Along with universal services becoming more of a priority, an increasing focus on service equity and self-management in [Clootshire B] made special arrangements for children with more severe SSD less possible. Clinic appointments had been "GRADUALLY whittled away" [C9], and even weekly intervention had become rare. Intervention, structured by the service's therapy plan template, placed greater expectations on parents or other therapy partners to carry out work prescribed by the therapist:

whereas before you would HAVE.. you would SEE them and you would say ((bright voice)) 'okay, I'll see you again next Thursday' or 'I'll see you in two weeks' or whenever it happens to BE, NOW I'm much more inclined to say 'right, ((slower voice)) I'm gonna give you THIS.. and I RECKON that'll PROBABLY take you about three weeks to work through? (pause) so we'll make an appointment in three weeks' time but if.. THREE WEEKS.. if that appointment comes AROUND.. and you think.. 'we're nowhere near REACHING that goal'.. give me a call.. and we'll reschedule the appointment for another TIME'.. and EQUALLY em.. 'if you.. RACE through that and you're, you know, your-you-you've cracked it really QUICKLY.. phone me and I'll send you out some MORE stuff... quicker' [[mhm]].. so you're trying to tailor it [C9]

Because the majority of caseload children with SSD responded to the intervention provided, specific interventions were seen as less important than therapy provision: "it's actually the fact that you're.. concentrating on speech in WHATEVER way it is.. that THAT'S what's making the difference" [C7].

In addition, the kind of service that *might* better support children with more severe problems was perceived as too far removed from reality, theoretically and logistically ("a bit of a LUXURY" [C9]), to be possible. Although it would be "GREAT", [C7] noted there was no guidance saying "this is likely to work with THIS child, this is not.. so likely to work and.. we've got the evidence behind it". Moreover, even where greater *intensity* might make a difference, there was no prospect of flexibility in the system:

for some children.. I think it's REALLY helpful to have.. very very regular.. THERAPY.. and-and all the follow-up that goes along with it, but that real CLOSE monitoring, particularly with speech.. difficulties.. em... and we just.. DON'T PROVIDE THAT. We don't. [C7]

Apart from a case for an instrumental intervention (6.1.1) across [Clootshire], there had been no pressure from staff to make SSD a strategic priority, although they had opportunities to raise it. For example, time was allocated during team meetings to discuss cases in threes (peer trios), protected learning time was used to look at the What Works website, and therapists could shadow colleagues. Rather than inspiring substantial changes in practice, What Works was used to pick up the "little.. practical ideas" that "you think ((reassured voice)) 'oh yeah, I can use THAT'" [C9].

Decisions on training were driven by what therapists requested, and the service was increasingly relying on a do-it-yourself model following the collapse of training budgets. For many years requests focused on autism, and SSD had not featured. However, a very recent event to choose topics for learning suggested this might be changing:

> phonological.. approaches.. were one of the things that people wanted to LOOK at. Which.. was SURPISED me, because I didn't think it WOULD be. [[right]] And that.. that's REALLY a FIRST. (pause) [C7]

9.3.4 [Staneshire]'s investment

A myriad of initiatives designed to bring together and develop the [Staneshire] service had implications for intervention for children with SSD. This section focuses on two which directly addressed SSD practice change, because they were most explanatory. The first was a test of a new SSD intervention pathway, and the second a long-standing network for therapists with an interest in SSD.

9.3.4.1 [Staneshire]: investing in an SSD intervention pathway

[Staneshire] had invested time, energy and resources in a new pathway and delivery model for SSD intervention. It was coming to the end of a test period which had lasted around 10 months.

This change came when senior management decided that, instead of receiving direct intervention, the default option for a new referral who "appeared to be a child.. who.. required some input for speech SOUNDS" [S3] should be a group parent workshop with a home pack. Although this Format had been used before for children with language and other communication difficulties, for those with SSD it was a break with the past:

> the difference in that was.. the fact that the CHILDREN weren't there it was all about supporting the parents and empowering the parents to do.. therapy at home. Em.. so that was quite DIFFERENT from.. from what we'd.. done TRADITIONALLY.. where it would be.. parent and child.. in the session and doing it together em.. so.. yeah.. two different ways of working. [S3]

The model emerged from one division, and the project was overseen by a working group that included therapists from all three. As it was intended as a

test, the workshop had to be delivered in exactly the same way, whoever was presenting.

Workshops were 2½ hours long and planned 3-4 months in advance at a variety of locations to offer parents a choice. Delivery and attendance were managed within each division using spreadsheets to which all the therapists had access. Therapists took turns doing the workshops in pairs so "you got to learn how to run them.. WITH.. another therapist?.. who'd done it before?" [S4].

Workshop content focused on equipping parents to work with their child on a specific sound selected by the assessing therapist. At the end of the workshop, parents were given the Black Sheep Press sound pack corresponding to their child's target sound, and an evaluation form to rate their satisfaction with the Format. The presenters would also "go ROUND" [S4] all parents at the end to make it "less.. daunting for them" to ask questions.

After an interval (variously described as '3 months', '8-12 weeks', '6-8 weeks'), the assessing therapist arranged a review appointment and either discharged the child, gave out a pack for another sound, or offered some other form of intervention. However, attendance had been "just really really poor" [S8] and a senior therapist was contacting parents to understand this.

Different therapists felt they had more or less discretion around allocating children to the pathway, but all indicated it was not suitable for children with severe or disordered SSD ("THAT was VERY much in conflict with things like the.. Core Vocabulary approach" [S2]). Even when a child had an apparently straightforward SSD, there was no guarantee this Format would be appropriate. The only criterion was that the child should be able to produce the target sound. As a consequence:

> a child that could do <s>.. and as.. soon as they came back from review this kid was doing <s:_da> so actually they never even got to CV[40] level.. [S8]

[S4] "quite liked it, it was quite good" because the initiative was an opportunity to work with other therapists and gave a feeling of "empowering the parents".

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[40] Consonant-Vowel

Although others were prepared to give the initiative a chance, it reduced their "autonomy" over intervention decisions and introduced a "hiatus" for the child [S5] which only rarely had the intended outcome for the child's speech or parental engagement:

> the intention was kind of that they would be generalising the sound into everyday speech.. and be discharged. And actually that wasn't the case.. em.. so I think we-we've LEARNT a lot from them, I think that they've been positive.. in actually how disastrous they've been?! There's been a lot kind of (laughter) ta-taken from it, and a lot of reflection and it's kind of.. that trial and errors, we've been able to identify actually.. the-they're not working, and everybody can now identify the solutions based on what didn't work. [S8]

Rather than being appropriate for the start of therapy, if used at all, [S2] felt it was more suited to the end. It was "too much too soon" [S3], without "making the right selection, doing the right PREPARATORY work" [S9] for each child.

Generally the workshop was perceived as a high level response to a number of pressures on the service: to manage numbers, to encourage self-management, and to standardise provision. However, as a "one size fits ALL" [S3], this had been at the expense of effective intervention and left the service questioning if it was "actually meeting.. the NEEDS of the parents.. or-or is it something that we've just (laughs) decided 'we're going to do because that gets people through.. the WAITING list faster'.." [S7].

9.3.4.2 [Staneshire]: investing in an SSD network

[Staneshire]'s strategic structure included cross-service networks with a clinical focus. SSD had been "quite a STRONG network" [S9], but attendance had fallen away as people were only allowed to be part of one, and speech was not necessarily their priority:

> as people's CASELOADS became more GENERALIST.. I actually think 'speech' kind of took a bit of a... em.. a bit of a-a BACK SEAT, which I think is a SHAME because I think.. actually we.. are speech and language therapists, WE have got UNIQUE skills that can support children with speech.. [S9]

The remaining members were re-thinking their focus, which was likely to include "trying OUT some of these new tech- the techniques that are on.. 'What Works' and things" [S9] and sharing their experience with the wider [Staneshire]

team. The language network had already engaged in this process, with knock-on effects for SSD intervention through a training event on Core Vocabulary and discussing SSD interventions featured on What Works.

9.3.5 Private practice's investment

As working privately "gives me the opportunity to REALLY concentrate on.. on my practice" [P3], these participants discussed investment in ongoing practice development rather than in a specific practice change. This was achieved through education, social support, and involvement with families.

9.3.5.1 Private practice: investing in education

Two private practice participants had attended multiple Caroline Bowen courses and other training relevant to SSD, and included non-traditional interventions in their repertoire. All three had used Caroline Bowen's web resources, and two had either directly or via a colleague been influenced by her against the use of non-speech oral motor exercises in SSD intervention. One had looked into the Talk Tools intervention at the request of a parent but "dismissed really quickly cos the evidence just looked SHOCKING for it" [P2]. Although she had always been proactive, outside the NHS [P1] was:

> part of more.. internet GROUPS.. and I see WHAT there is.. out there.. more. And I don't GRUDGE DOING it. Whereas BEFORE.. it was SO much WORKING.. WITH the patients.. and very little TIME.. to do as much as I could.

9.3.5.2 Private practice: investing in social support

The Association of Speech & Language Therapists in Independent Practice offered online and offline connections to colleagues where tricky cases could be discussed and questions asked about interventions. Having an NHS therapist also working with a client was a further opportunity to discuss intervention, as was balancing private with NHS work. Indeed, private practice could be less isolating than the NHS:

> I don't feel as alone as I DID because actually I HAVE other therapists, private therapist.. that I speak to more often than I did when I was working with a LOT of people, and THAT'S an interesting thing, I wasn't EXPECTING that. [P1]

9.3.5.3 *Private practice: investing in involvement with families*

While [P3] had been in a "em.. I don't know what the word IS.. eh..
PRIVILEGED!.. position" to develop her passion for SSD throughout her career,
private work gave opportunities not generally available in the NHS. These
included seeing clients in their own homes, having flexibility over appointments,
and taking more time to plan, reflect, and explain intervention to clients and
their families. They felt "spending more time with parents and.. being more in
their world" [P2] enabled them to offer intervention that was more meaningful,
realistic and effective.

9.4 Dimension: expectations

Participants perceived service expectations as important, and used them to
inform ongoing self-evaluation of whether they were doing a good job.
However, even within a service, participants experienced the same
expectations differently depending on how they felt about competing narratives.
Sometimes expectations were clear and persuasive:

> well, it's the current philosophy out there in... health AND social care
> really, is.. is moving MUCH more towards... supporting people to.. manage
> THEMSELVES.. rather than swooping in with solutions… more
> sustainable I suppose? Is the current buzz- THING, but I, but it feels
> RIGHT, I think it feels appropriate... [S12]

At other times, expectations were clear but left participants disappointed,
resentful or exasperated:

> I think that's the thing about.. top-down, bottom-up change that… you
> need to have therapists on board and.. em.. feeling that we're providing a
> GOOD service, not just.. something that's managing the waiting list
> (pause) [S2]

Participants also experienced expectations as mixed messages, leaving them
uncertain and confused about the right way to act. In spite of "an awful lot of
TALK lately about.. evidence-based practice", [S5] read up on interventions at
home because:

> I didn't necessarily feel that.. it was.. what my boss might be WANTING
> me to spend my time on, d'you know? so that's ALSO why I do it at home

because I almost feel it's a bit.. it wouldn't be maybe what.. I should be doing at work?

Everyone in [Blaeshire] was clear about "the broad parameters that they must work within" [B10], so mixed messages could be galling on the rare occasions they occurred. [B14] felt "aggrieved" that energy (at work and at home) on a project in line with service expectations lost its value when something else "took over" the management's "MINDSET". In [Clootshire] and [Staneshire], staff seemed resigned to expectations being in flux:

> there's been lots of CHANGES and.. the change PROCESS.. so I sometimes feel (pause) I'm not always a hundred per cent of where.. where ARE we, how is it.. WHERE are we working for, I kinda sometimes feel we're a bit.. kin- I'm quite.. ((taps desk for comic effect))] 'this is how I'm doing it and this is how I'm carrying on, and IS THAT RIGHT?' 'Yes I think that seems to be the way we're going' ((relieved voice for comic effect)) So we're going that way [S11]

Changing service expectations were often shaped by policy, and all NHS services were subject to the same professional and Scottish political pressures. [Staneshire], [Clootshire A] and [Clootshire B], for example, were redistributing resources towards universal and targeted levels:

> we're SHIFTING from this em.. sort of.. one-to-one style of therapy more towards the.. em... preventative world.. how are we going to.. DROP some- cos we're not getting extra MONEY or extra.. STAFFING to do- what are we going to STOP doing over HERE.. that we're going to.. PICK UP over here [S7]

In contrast, [Blaeshire] had tackled this previously through an initiative to build capacity. All staff were brought together for a week to address "a general FEELING" that "input to schools was largely ineffective?" [B18]. Rather than 'isolated' offers of training to individual teachers there was now "negotiation" about what was "achievable" and sustainable [B5]. Although this work was ongoing, it was an established part of the service.

9.4.1 Competing SSD expectations

To identify different service expectations that had implications for SSD practice change I used ethnodramatic monologues (Figure 9-2).

Figure 9-2: Expectation monologues

There will never be enough speech and language therapists to meet the need that's out there, but in any case communication is everyone's job. Parents, early years' practitioners and teachers have far more opportunities than we do to support children's speech and language development, but they're not walking round with all the knowledge we have. So we have to stop hiding behind the clinic door and do all we can to mainstream our knowledge and empower other people. Whether on social media, at drop-ins, parent groups, or through twilight sessions and in-service training for teachers, we need to SHARE simple, key messages in creative ways that reach more people and make them as enthusiastic about communication as we are!

There will never be enough speech and language therapists to meet the need that's out there, but communication is everyone's job, not just ours. Every public service is under pressure to do more with less - I honestly don't know how schools manage with all they're asked to implement - and families have busy lives too. This makes it essential to work on good relationships and have some flexibility, so that together we can agree what the problem is and discuss what we each might bring to the table. So whether we're sorting out clinic space, organising training for teachers, or keeping parents on board, we need to NEGOTIATE our contribution and spread the load so that, together, we make a difference.

There will never be enough speech and language therapists to meet the need that's out there. And yes, communication is everyone's job, but we mustn't lose sight of the fact that some children depend on our unique skills. SSD is our bag, and for too long it's been the poor relation. It's time to stop kidding ourselves that all children with SSD need our specialist intervention, that any speech and language therapy is better than none, or that other people can do phonological intervention after a couple of hours of training. Instead we need to hone our skills and DESIGN our intervention so that we can work more effectively and efficiently with the children and families who really need us.

These cultural narratives untangled as competing expectations to 'Share', 'Negotiate' or 'Design'. All three monologues were generated from expectations in all services, and sharing, negotiating and designing were features of all participants' practice. However, each service had a dominant expectation (Table 9-3), which helped explain the trajectory of SSD practice change.

Table 9-3: Dominant expectations in services

Dominant expectation	Service
Share	[Staneshire], [Clootshire B]
Negotiate	[Clootshire A]
Design	[Blaeshire], private practice

9.5 Dimension: possibilities

Using a retroductive strategy (2.2.4.3), I considered which broad types of SSD intervention were possible and, conversely, *not* possible in the different services (Table 9-4).

Table 9-4: Possible and not possible interventions

	Routinely possible	Not routinely possible
Blaeshire	Enhanced direct intervention Non-traditional interventions Group intervention*	Pathway approach Exclusive use of traditional intervention
Clootshire A	Negotiated direct intervention Intensive intervention period Group intervention EPG[41]* Non-mainstream intervention*	Non-traditional interventions**
Clootshire B	Traditional intervention Emphasis towards intervention via parents / education services Group intervention*	EPG Weekly direct intervention
Staneshire	Pathway approach (indirect intervention via parent) Traditional intervention Group intervention*	Non-traditional approaches** Enhanced direct intervention Intensive intervention period
Private	Enhanced direct intervention	

*Part of service in at least one hub or division

**Forays by individual or informal groups of therapists

The explanatory value of this table was enhanced in three ways. Firstly (based on earlier analysis of how participants reported de-implementation), I restricted it to intervention that was *routinely* possible or not possible. This took into

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[41] An instrumental intervention

account the considerable agency participants had over intervention, and enabled me to think about where and why there were exceptions. Recognising, for example, that non-traditional interventions were routinely possible by individuals or informal groups of therapists in some services confirmed the extent of therapists' agency. It also drew my attention to a similar pattern in [Blaeshire] prior to their SSD initiative, suggesting such ventures may be necessary but not sufficient for practice change across a service:

> when we were first [[right]] starting out.. there were little FORAYS.. [[yeah]] into doing slightly different [[yeah]] things with some of the.. good.. therapists [B10]

Secondly, I aimed to have only as many categories as necessary to show service differences that mattered. 'Enhanced direct intervention', for example, incorporated linguistic or person-centred enhancement because both implied greater use of the therapist's specific skills.

Thirdly, I noticed the silences. This drew my attention to awareness that an intervention was possible in a community setting as a necessary but insufficient condition for wanting to offer it. [Clootshire], for example, was undergoing a service reorganisation. Part of its purpose was to spread resources more equitably, but an instrumental and a non-mainstream intervention continued to be available to clients in one part but not in others. While inequity over the non-mainstream intervention was disregarded, the instrumental intervention was perceived as an entitlement:

> we've got kids on the caseload that... REALLY could DO with it! And if they were seen in [name of hub].. they'd be getting it (pause) [C5]

9.6 From Service to case configuration

This chapter has discussed the Service aspect of the practice context for SSD practice change. I have shown how similarities and differences in the way services were organised, how they had invested in SSD at the specialist level, their dominant expectations of staff, and what was routinely possible or not possible had implications for the trajectory of change.

In the following chapter, I will pull all four aspects of the practice context together - Intervention, Candidacy, Caseload, Service - to configure cases of practice change and propose key mechanisms which enabled them to emerge.

10 Case configuration and practical social theory

The theory of SSD practice change is a practical social theory explaining how and why community speech and language therapists changed their practice for children with SSD (Figure 5-1, reproduced below). It identifies six trajectories (cases) of practice change emerging through four interdependent aspects of the practice context: Intervention, Candidacy, Caseload and Service. In chapters 6-9, I explored similarities and differences in each aspect which were most relevant to practice change. In this chapter, I pull the findings from these chapters together to configure the cases, showing how they came to be one way rather than another.
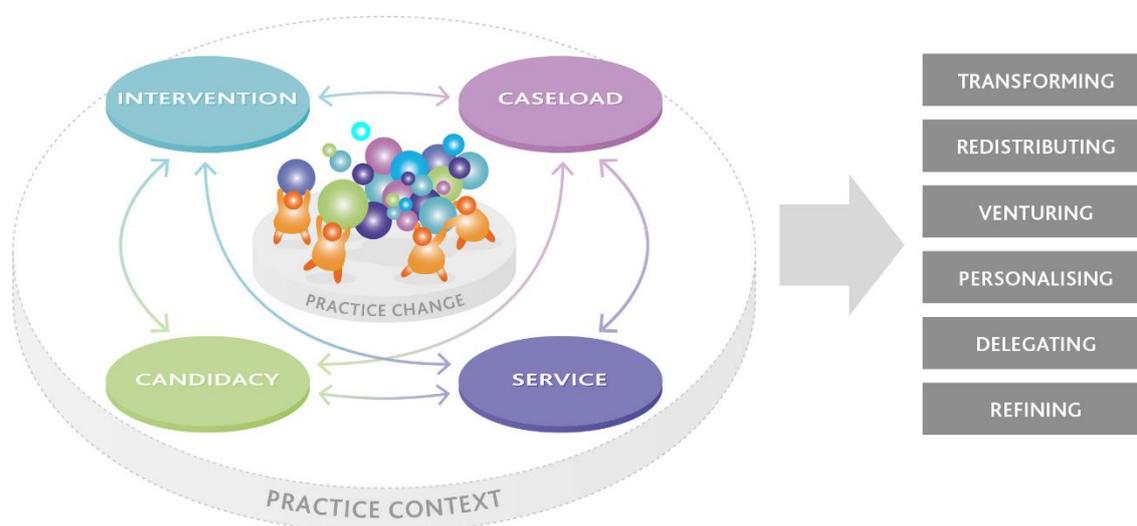
I first suggest what cases as complex configurations ask of you, the reader (10.1). I then show how each aspect of the practice context contributed to each case, and how tracking this helped me to construct a comparative configuration table (10.2). In 10.3, after discussing each case and its configuration, I reflect on key mechanism(s) which appeared to make it possible.

10.1 Cases as complex configurations

Readers should bear in mind that the cases of practice change refer to everyday complex, integrated speech and language therapy work into which new ideas about practice and interventions are introduced. They do not make

more familiar comparisons, such as implementation of new versus old interventions, assessments, caseload models, or service models. Neither do they compare one service with another, or different methods of training, facilitation or decision-making. Instead, they compare SSD practice change within and across all aspects of the immediate practice context, thus accounting for depth and breadth of each. This type of comparison is fundamental to identifying what 'work' is transferable to other settings.

Readers should also note that the labels for the cases are everyday words, but are used with a specific meaning. The cases should therefore be read with reference to their associated descriptions (Table 10-1).

Table 10-1: Case labels and descriptors

Case	Description
Transforming	Non-traditional SSD interventions for selected children becoming part of local routine practice
Redistributing	Negotiated periods of intensive intervention for selected children with SSD becoming part of local routine practice
Venturing	Individual or informal groups of therapists trying out or using interventions that are not part of local routine practice with selected children with SSD
Personalising	Highly personalised intervention becoming part of local routine practice with children with SSD
Delegating	Specialist SSD intervention via a therapy partner becoming part of local routine practice
Refining	Individual or informal groups of therapists making ongoing adjustments to intervention for children with SSD

Another challenge in accounting for complexity was the point at which characteristics of cases came into being. What, for example, tipped local routine practice into practice that was not local, or not routine? Traditional SSD interventions to non-traditional ones? Trying something out to using it? Informal groups of therapists to formal ones? Personalised intervention to highly personalised? Intervention *including* a therapy partner to that *via* a therapy partner? As these decisions were a matter of judgement based on immersion in

the research topic and scene, they are best understood not as rigidly bounded categories but as ideas about the nature and extent of differences that made a difference to these trajectories of practice change.

10.2 How practice context contributed to case configuration

In recognising the four aspects of the practice context most implicated in the SSD practice changes discussed by participants, I also considered how each aspect related to different trajectories. This entailed constant questioning about what seemed necessary / not necessary, present / absent, and possible / not possible within and across the practice context. Sections 10.2.1-10.2.4 discuss how each aspect contributed to case configuration.

10.2.1 Contribution of the Intervention aspect

Although individual elements of the SSD intervention change model helped explain within-case variation, the *layers* of the model were sufficient to help explain the different cases (Figure 6-1, reproduced below). This is important because each entailed particular work: theoretical (intellectual work), logistical (organisational work), processual (relational work) and observable (creative work).
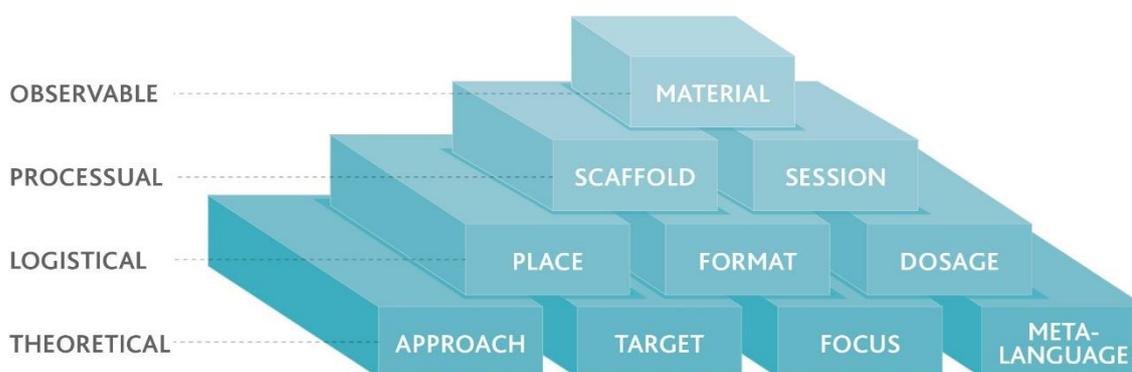
Table 10-2 shows where changes in a layer of the model were necessary for that case to emerge. A dash indicates that such changes, even if they happened, were not necessary for that case to be so. While the point at which a layer change tipped from not necessary to necessary was a judgement,

comparing the patterns for each case is illuminating, as they show both the number of layers necessary for a case, and the types.

Table 10-2: Necessary changes in Intervention layers

	Theoretical	Logistical	Processual	Observable
Transforming	Necessary	Necessary	Necessary	Necessary
Redistributing	-	Necessary	-	-
Venturing	Necessary	-	Necessary	Necessary
Personalising	-	Necessary	-	Necessary
Delegating	*Not possible*	Necessary	-	-
Refining	-	-	-	-

Transforming was the only case which depended on work at every layer of SSD intervention. As this case was only present in one service (Table 10-6), and work on the logistical layer had predated work on the theoretical layer, it is not clear whether it would have been possible to address all layers at once.

Redistributing only needed work on the logistical layer. It was therefore possible for the content of therapy to remain the same, while being delivered more intensively and involving more people across different settings. The Delegating case also only required work on the logistical layer. However, while it was possible to work on changes to other layers when Redistributing, with the Delegating case it was not possible to address the theoretical layer. In contrast, for Personalising, logistical and observable change was needed, but it was also possible to work on other layers. While Redistributing and Personalising therefore had the potential to provide a platform for Transforming, it is difficult to imagine how Delegating could do the same.

The logistical work required for the Redistributing, Personalising and Delegating cases to emerge depended on what was happening in the Service aspect (10.2.4). Venturing, on the other hand, entailed work on every Intervention layer *except* logistics. This case was dependent on individuals or informal groups rather than - and sometimes in spite of - the Service, and on the considerable agency participants had over the content of intervention. Agency over the content of intervention also made Refining possible through experience and

reflection, irrespective of what work was going on in any layer of the intervention model.

10.2.2 Contribution of the Candidacy aspect

The two dimensions of the Candidacy aspect of the practice context - specialist SSD knowledge and a therapeutic sensibility - were sufficient to help differentiate the trajectories of practice change if *depth* was the critical consideration. Table 10-3 charts whether depth of either was necessary for the emergence of a case. 'Neutral' indicates depth may or may not have been present, but was not necessary to the case.

Table 10-3: Depth of Candidacy dimensions

	Specialist SSD knowledge	**Therapeutic sensibility**
Transforming	Depth	Depth
Redistributing	Neutral	Depth
Venturing	Depth	Neutral
Personalising	Depth	Depth
Delegating	Neutral	Neutral
Refining	Neutral	Neutral

As with the Intervention aspect, where changes in all four layers of the model were necessary, the Transforming case depended on depth of both Candidacy dimensions. Similarly, the Refining case did not depend on any Intervention layer changes, and was neutral for both Candidacy dimensions. The interaction between the Intervention and Candidacy aspects reinforces differences in the work required for the Transforming and Refining cases.

This interaction for the emergence of different cases is also seen in the contrast between Redistributing and Venturing. While Redistributing depended on work to change the logistical layer of intervention and depth of therapeutic sensibility, it was neutral on specialist SSD knowledge. Venturing, however, depended on work at the theoretical, processual and observable layers of intervention, and depth of specialist SSD knowledge. It did not need work at the logistical layer, and was neutral on depth of therapeutic sensibility.

The Delegating case provides further support for interaction between the Intervention and Candidacy aspects of the practice context in practice change. Changes in the theoretical layer of Intervention were not possible in the Delegating case, and depth was neutral in both Candidacy dimensions. This contrasts strongly with the Personalising case, where changes in the theoretical layer of Intervention were possible and depth in both Candidacy dimensions was necessary. Just as it was difficult to imagine how Delegating could provide a platform for Transforming, this suggests that Delegating is unlikely to make Personalising possible either.

10.2.3 Contribution of the Caseload aspect

The Caseload dimensions of size, composition, time and distribution are mapped descriptively in Table 10-4 to show how they helped differentiate cases. Again, interactions between different aspects of the practice context are evident.

Table 10-4: Descriptions of Caseload dimensions

	Size	**Composition**	**Time**	**Distribution**
Transforming	Capped	Based on depth of Candidacy dimensions	Critical reflection	Distributed
Redistributing	Neutral	Based on depth of therapeutic sensibility (Candidacy) and presence of children with severe SSD	Neutral	Distributed
Venturing	Neutral	Presence of children with severe SSD	Neutral	Not distributed
Personalising	Capped	Neutral	Flexible	Not applicable
Delegating	High	Based on service equity	Viewed as caseload management problem	Centralised
Refining	Neutral	Presence of children with SSD	Neutral	Neutral

The biggest Caseload contrast differentiated the Transforming and Delegating cases. Transforming depended on capped caseloads, composition based on depth of Candidacy judgements, a critical understanding of the role of time on caseload, and distribution of caseload work. Delegating depended on caseloads being high, composition based on a principle of service equity, time on caseload being seen as a management problem, and a centralised hold on caseload work. On this basis, it is possible for a speech and language therapy session with a child with SSD to look similar but be poles apart philosophically; this has considerable implications for what it would take to implement a new intervention in settings characterised by one case or the other.

Refining again stood out as relatively removed from whatever was happening in the practice context, because the only necessary Caseload dimension for this case related to composition. For Refining to emerge, children with SSD merely had to be present on the caseload, whether or not the SSD was severe. Severity of SSD as part of Caseload composition became important for both the Venturing and Redistributing cases, with Redistributing further differentiated by the additional contribution of depth of therapeutic sensibility (Candidacy).

The distribution dimension of the Caseload aspect helps explain why the agency necessary to the Venturing case could continue, as its caseload work was neither distributed nor centralised. It also supports the argument that Redistributing may be a necessary precursor to Transforming because distribution of Caseload work was common to both. Likewise, the size dimension of the Caseload aspect helped explain how the Personalising and Transforming cases could have depth in both Candidacy dimensions, as a capped caseload allowed extra time to invest in each individual client.

10.2.4 Contribution of the Service aspect

As the other three aspects of the practice context were heavily interwoven with the Service aspect, its contribution to the configuration is arranged slightly differently. The 'organisational model' and 'possibilities' dimensions are reported in chapter 9; they fed into the decision to divide the three participating services and private practice into five service contexts. Here, the five service contexts are considered first in relation to the other two Service dimensions -

investment in specialist SSD and most salient expectation narrative - and then to the cases of practice change.

Table 10-5 shows the five service contexts with a description of their investment in SSD at the specialist level (9.3) and the most salient expectation narrative (9.4) in that service context.

Table 10-5: Dimensions of Service aspect

	Investment in specialist SSD	**Salient expectation**
[Blaeshire]	• Personal leadership • Facilitation • Social learning • Transfer to students	Design
[Clootshire A]	• Personal leadership • Attention to effectiveness	Negotiate
[Clootshire B]	• Not necessary	Share
[Staneshire]	• SSD intervention pathway • SSD clinical network	Share
Private practice	• Learning (formal / social) • Involvement with families	Design

This comparison draws attention to similarities in investment in learning and expectations of 'Design' between [Blaeshire] and private practice, and to the relevance of personal leadership on specialist SSD by managers in [Blaeshire] and [Clootshire A]. It also highlights the 'Share' expectation as most salient in [Clootshire B] and [Staneshire], where investment in the specialist level of SSD was either not necessary or focused on pathways.

Table 10-6 shows the relationship between the six cases of practice change and the five service contexts. The case which stood out in each is marked as salient, and others which were apparent are marked as present. Because salience assumes presence, both are in italics to enhance comparison. Where there was insufficient evidence of a case, it is marked as absent or neutral depending on my confidence in this judgement. These categorisations should be read as applying only to the cases *as I have described them* (Table 10-1),

not to any other types of transformation or redistribution that may be going on in these service contexts.

Table 10-6: Relationship between cases and service contexts

	Blae	**Cloot A**	**Cloot B**	**Stane**	**Private**
Transforming	*Salient*	Neutral	Absent	Absent	Neutral
Redistributing	*Present*	*Salient*	Absent	Absent	Neutral
Venturing	Absent	*Present*	*Present*	*Salient*	*Present*
Personalising	Neutral	Neutral	Neutral	Neutral	*Salient*
Delegating	Neutral	Neutral	*Salient*	*Present*	Neutral
Refining	*Present*	*Present*	*Present*	*Present*	*Present*

Refining was the only case present in all service contexts, suggesting it was largely independent of the Service aspect of the practice context. Patterns of presence, neutrality and absence were the same for [Clootshire B] and [Staneshire], and both had a dominant expectation narrative of 'Share' (Table 10-5). This raised questions about what made it possible for Transforming and Redistributing to be absent, but Venturing and Delegating present in both, and why one of these was more salient than the other. Comparing the investment dimension of Service with Candidacy suggests the SSD clinical network in [Staneshire] provided architecture that protected the depth of specialist SSD knowledge needed for the Candidacy dimension for Venturing, whilst the SSD intervention pathway worked against depth in both Candidacy dimensions as seen in the Delegating case.

The absence of Venturing in [Blaeshire] is of note, as it was present in all other service contexts. This made me wonder if the changes across the practice context in [Blaeshire] which enabled Transforming to emerge also required a reduction in therapists' agency - or if it simply meant there was less need for them to direct their agency to Venturing? Comparing the profiles of [Blaeshire] and [Clootshire A] again does not disconfirm the idea that the case of Redistributing may be a necessary precursor to that of Transforming.

Private practice stands out as different in this comparison, as it was most salient in the Personalising case where all other service contexts were neutral.

A number of participants across all service contexts placed great importance on personalising intervention, but only private practice met the criteria for the Personalising case. This neutrality versus salience may again demonstrate therapists' agency over their intervention, whatever constraints are imposed by the practice context. For those in private practice, practice change may also follow a particular trajectory (Personalising) because of the other Service dimensions (investing in involvement with families, and an expectation narrative of 'Design').

10.2.5 From practice context to cases of practice change

In this section I have discussed the main ways each key aspect of the practice context contributed to the cases of practice change, and have begun to consider how their dimensions intersected to explain the different trajectories. In 10.3, I will move the focus from each aspect of the practice context to each case. To support this discussion, the contribution of the practice context to each case is summarised in a configuration table completed as follows:

- If practice change in an Intervention layer was necessary to that case, the label for that layer is included (theoretical / logistical / processual / what is observable). If it was not necessary (even if it happened), the label is not included.

- For Candidacy, the key word is 'depth'. If depth of either specialist SSD knowledge or therapeutic sensibility was necessary to that case, it is included. If it was not necessary (even if it happened), it is not included.

- Description of any dimension of the Caseload aspect (size / composition / time on caseload / distribution of work) which helped differentiate that case.

- For the Service aspect, the participating service where this case was most salient is named, as is any other service where the case was evident; this accounts for the dimensions 'organisational model' and 'possibilities'. The dominant service expectation narrative is included, as is a description of the service's investment in SSD.

10.3 Configured cases of SSD practice change

Section 10.2 considered how each aspect of the practice context had contributed to the different trajectories of practice change. In this section I will focus on the cases themselves. Each case opens with its definition and a summary configuration table. Sections of the table are deliberately left blank if they did not contribute to explaining how and why the case emerged. However, these spaces - silences - are just as important because they help to make sense of why a case did not come to be another case instead. Each table is followed by a discussion and suggested key mechanism(s) which enabled that particular trajectory.

10.3.1 Transforming case

The Transforming case (Table 10-7) emerged as non-traditional SSD interventions for selected children becoming part of local routine practice.

Table 10-7: Summary of Transforming case

TRANSFORMING CASE				
Aspect	**Dimensions and descriptions**			
Intervention	Theoretical	Logistical	Processual	Observable
Candidacy	Depth of specialist knowledge		Depth of therapeutic sensibility	
Caseload	Size: *Capped*	Composition: *Depth of Candidacy dimensions*	Time: *Critical reflection*	Distribution: *Distributed*
Service	Most salient in: [Blaeshire]	Investment: *Leadership Facilitation Social learning Students*	Expectation: Design	Also seen in:

Transforming was only seen in [Blaeshire]. At face value, this case came about because of an SSD initiative; staff attended training by a credible knowledge broker (Caroline Bowen) and cascaded this learning locally. However, attempts to replicate these actions in the hope of Transforming practice would be unlikely to yield [Blaeshire]'s outcome because vital information about the complex

contribution of the practice context would have been missed. Examining the Transforming case's configuration gives a more realistic picture of what it might take.

Although the Transforming case description is ostensibly about changing the Intervention aspect of practice, Table 10-7 shows it took quantitative and qualitative differences right across the practice context to explain its emergence. Work was needed at all four layers of the Intervention aspect, together with depth of both Candidacy aspects (the latter only seen in one other case, Personalising). The Caseload aspect was capped and distributed, and the Service aspect was characterised by a variety of investments in SSD at the specialist level and an expectation of 'Design'. In comparison, all other case configurations were less populated, lending support to the argument that Transforming was not uniquely seen in [Blaeshire] through luck or some innate quality, but because of their multi-dimensional work in the practice context.

Given this explanatory detail, it becomes clear that Transforming was possible in [Blaeshire] because a credible knowledge broker (Caroline Bowen) raised awareness that non-traditional Interventions existed, and managers saw it as a solution to a perceived problem with SSD effectiveness. Their investment in an SSD initiative built on earlier planned and sustained work to have a consistent, transparent and critical approach to identifying suitable Candidates for starting, continuing with and ending specialist intervention. Capped caseloads and a distributed (social) approach to Caseloads meant participants from that Service were not only expected to implement the non-traditional interventions through 'Design' to suit individual needs, but in practice had the capacity to do so.

Supported by textbooks and journal articles and a social approach to learning, the move to routine local use of non-traditional interventions such as a Complexity Approach, Core Vocabulary and Multiple Oppositions was nonetheless experienced as stressful, confusing, confronting, frustrating, surprising, stimulating and rewarding. This is understandable because changing theoretical, logistical, processual and observable layers of Intervention took a combination of intellectual, organisational, relational and creative work.

Taken as a whole, it is likely that key mechanisms underpinning this case of practice change were related both to the specialist knowledge inherent in speech and language therapy work and a practical understanding that learning is complex and social. Two mechanisms which I suspect would have to be invoked for the Transforming case to be possible are:

- Pride in the contribution of unique linguistic skills to speech and language therapy effectiveness
- A culture of external and internal facilitation

10.3.2 Redistributing case

The Redistributing case (Table 10-8) involved negotiated periods of intensive intervention for selected children with SSD becoming part of local routine practice.

Table 10-8: Summary of Redistributing case

REDISTRIBUTING CASE				
Aspect	**Dimensions and descriptions**			
Intervention		Logistical		
Candidacy			Depth of therapeutic sensibility	
Caseload	Size:	Composition: *Depth of therapeutic sensibility (Candidacy) and presence of children with severe SSD*	Time:	Distribution: *Distributed*
Service	Most salient in: [Clootshire A]	Investment: *Leadership Attention to effectiveness*	Expectation: Negotiate	Also seen in: [Blaeshire]

Many participants believed they would be more effective if they could offer clients more therapy. Within all service contexts, periods of intensive intervention were negotiated, but this always depended on some special

circumstances and additional resource. Redistributing only constitutes a case of practice change when periods of intensive intervention become part of what is routine rather than the exception.

At face value, Redistributing is about becoming more effective through increasing the Dosage element of Intervention. However, simply increasing Dosage would be unlikely to have the same outcome because it misses the point that Redistributing depends on work at the logistical *layer* of Intervention, and other changes across the practice context.

Redistributing was only possible when therapists had both the agency to adjust the logistical layer of Intervention, and the depth of therapeutic sensibility in the Candidacy aspect of the practice context to negotiate periods of greater intensity for the children who would most benefit. Flexibility with the logistical layer of Intervention in turn depended on a distributed approach to Caseload work, and Service permission to attend to effectiveness then 'Negotiate' to make it happen.

Redistributing is therefore a much more social phenomenon than increasing Dosage. It depends on bringing joint attention to the work of making a difference to the child with SSD, and enabling everyone to recognise what they can contribute. This means the key mechanisms underpinning Redistributing are likely to refer both to distribution and to agency within and beyond speech and language therapy. My impression is that two mechanisms necessary for Redistributing are:

- Distributed agency over the logistical layer of Intervention
- A culture of distributed decision-making that respects what different specialist knowledge can contribute

Redistributing was most salient in [Clootshire A], but also seen in [Blaeshire]. As seen throughout 10.2, configuring the cases offered compelling evidence that Redistributing may be a necessary precursor to the Transforming case. Redistributing introduces flexibility to the system, which is seen to make a difference to children. It is possible this creates a platform for therapists to start questioning what more they could achieve for selected children by doing other things differently too.

10.3.3 Venturing case

When Venturing (Table 10-9), individual or informal groups of therapists were trying out or using interventions that were not part of local routine practice with selected children with SSD.

Table 10-9: Summary of Venturing case

VENTURING CASE				
Aspect	**Dimensions and descriptions**			
Intervention	Theoretical		Processual	Observable
Candidacy	Depth of specialist knowledge			
Caseload	Size:	Composition: *Presence of children with more severe SSD*	Time:	Distribution: *Not distributed*
Service	Most salient in: [Staneshire]	Investment: *SSD intervention pathway SSD clinical network*	Expectation: Share	Also seen in: [Clootshire A] [Clootshire B] Private practice

Individual therapists and informal groups had tried out or were using non-traditional or non-mainstream (6.1.1) named interventions with selected children who had severe or persistent SSD; some also made personalised intervention a priority. The range and type of interventions seen in Venturing was therefore greater than in Transforming, but were not necessarily applied or sustained systematically. Awareness that alternatives to local routine practice existed also came via a more diffuse variety of sources.

At face value, Venturing was about individual therapists putting effort into evidence-based practice, improvement and innovation. However, the configuration reveals the extent to which Venturing is socially shaped and constrained by the Service aspect and its influence across the practice context.

When therapists had children with severe SSD on their Caseload, they felt the responsibility of their specialist knowledge (Candidacy), so looked for practical solutions. Venturing was possible because they had considerable agency over the content of what they did (theoretical, processual and observable layers of Intervention), and Caseload work was not distributed.

However, this was constrained by lack of direction, enthusiasm and support from the Service aspect to invest in these Intervention layers and Candidacy dimension. As a result, access to sources and resources, level of critical appraisal, attention to fidelity and effectiveness, and sustained use varied widely. It also at times made therapists cautious over how and with whom they discussed what they were doing. This helps explain why Venturing could spread particular ideas more than others in different settings, and why (although examples were rare) it was possible for non-mainstream approaches to enter practice.

The influence of the Service aspect manifested most perniciously as lack of agency to be flexible with the logistical layer of Intervention. Accepting this as a fait accompli, therapists exercised the agency they did have to make greater adaptations to named interventions.

Venturing emerged in all service contexts except [Blaeshire], although evidence of its past existence in [Blaeshire] and signs that it was no longer possible, informed the case configuration. It was seen most prominently in [Staneshire] where there was tension in the Service aspect. On the one hand, efforts to standardise SSD Intervention through a parent group pathway and a dominant 'Share' expectation were pushing the Service in a Delegating direction. However, the presence of clinical networks, including one for SSD, along with individuals keen to use their specialist SSD knowledge, maintained a pull which enabled Venturing. This suggests the key mechanism underpinning Venturing is:

- A culture of individual professional responsibility to provide more effective therapy within existing constraints

10.3.4 Personalising case

The Personalising case (Table 10-10) emerged as highly personalised intervention becoming part of local routine practice with children with SSD.

Table 10-10: Summary of Personalising case

PERSONALISING CASE				
Aspect	**Dimensions and descriptions**			
Intervention		Logistical		Observable
Candidacy	Depth of specialist knowledge		Depth of therapeutic sensibility	
Caseload	Size: *Capped*	Composition:	Time: *Flexible*	Distribution: *Not applicable*
Service	Most salient in: Private practice	Investment: *Learning (formal / social) Involvement with families*	Expectation: Design	Also seen in:

Across the sample, there was evidence of personalisation of elements of Intervention, particularly where participants valued a functional Approach, adapted the Scaffold, and customised Material to a child's interests. The Personalising *case* was only seen in private practice, but it would be a mistake to infer a simple relationship. At face value, Personalising came about through providing Intervention in a child's home rather than a clinic or school. However, as with Transforming and [Blaeshire], the case configuration shows that what it really took for Personalising to emerge can be abstracted from the particular service setting.

Personalising depended on attention to the logistical and observable layers of Intervention. This was largely provided in a child's home, with family involvement, and capitalised on family routines and relationships as well as the child's interests and favoured toys or pastimes. It also depended on the time afforded by capped and flexible Caseloads. This was used for depth of Candidacy judgements, supported by Service investment in learning and involvement with families, and establishing a shared expectation of 'Design' for that child.

The case configuration was informed not just by the relatively small and self-selecting sample of participants from private practice, but by applying the study's underpinning questions (Figure 4-9) to the whole. My analysis suggests the key mechanism triggered was:

- Privileged access to the family

10.3.5 Delegating case

The Delegating case (Table 10-11) referred to specialist SSD intervention via a therapy partner becoming part of local routine practice.

Table 10-11: Summary of Delegating case

DELEGATING CASE				
Aspect	**Dimensions and descriptions**			
Intervention Candidacy	*Not possible*	Logistical		
Caseload	Size: *High*	Composition: *Based on service equity*	Time: *Viewed as caseload management problem*	Distribution: *Centralised*
Service	Most salient in: [Clootshire B]	Investment: *Not necessary*	Expectation: Share	Also seen in: [Staneshire]

The term 'therapy partner' was used across the sample to denote the main person working with the speech and language therapist to help a particular child with SSD at the specialist level. This was usually, but not always, a parent. The distribution of work between a therapist and a therapy partner varied widely. However, Delegating was distinguished when responsibility for carrying out the therapist's specialist SSD work was routinely rather than exceptionally handed over to the therapy partner to complete over a period of weeks. Participants had a variety of opinions on specialist SSD Intervention being delivered via rather than with a therapy partner, ranging from tentative support to suspicion and despair. By considering all aspects of the practice context for this case, the

configuration cannot resolve these feelings, but at least offers greater clarity as a basis for discussion.

The Caseload aspect was dominant in distinguishing Delegating from other cases. It depended on high caseloads, and time spent on caseloads being conceptualised as a caseload management problem. Solutions were to centralise caseload work and apply a principle of service equity to caseload composition. Therapists' agency was further reduced by the absence of depth in both Candidacy dimensions, the Service directive to standardise the logistical layer of Intervention (for example to work in schools or via parent groups), and the way Delegating made work at the theoretical layer of Intervention not possible. This was complemented by a Service aspect where particular investment in the specialist level of SSD was seen as unnecessary because the dominant expectation was to 'Share' knowledge and skills to encourage self-management.

Delegating was most salient in [Clootshire B], and also seen in [Staneshire]. On the surface it looked quite different, because in the former it applied to individual therapy partnerships and in the latter to parent groups. However, across the practice context the same explanation for its emergence applied. It seemed two key mechanisms had to be operating in tandem:

- Desire to provide an equitable service within constraints
- Doubt about potential return on investment in SSD at the specialist level

10.3.6 Refining case

The Refining case (Table 10-12) referred to individual or informal groups of therapists making ongoing adjustments to intervention for children with SSD through experience and reflection.

Given how unexceptional and ubiquitous Refining was, it could have gone unnoticed as a *case* of practice change. However, reporting rather than assuming its configuration helps us make sense of how - in contrast to every other case - Refining was possible *without* change in the practice context.

Table 10-12: Summary of Refining case

REFINING CASE				
Aspect	**Dimensions and descriptions**			
Intervention				
Candidacy				
Caseload	Size:	Composition: *Presence of children with SSD*	Time:	Distribution:
Service	Most salient in:	Investment: *(Personal?)*	Expectation: *(Reflective practice?)*	Also seen in: [Blaeshire] [Clootshire A] [Clootshire B] [Staneshire] Private practice

The variety of practice changes and illustrative examples offered by participants suggested they constantly reflected and built on their experience. This did not appear to depend on what was happening in the Intervention, Candidacy or Service aspects of the practice context, and only depended on a Caseload presence of children with SSD.

Although the extent to which participants were used to discussing and openly defending their decision-making varied, it seemed the expectation of 'reflective practice' as a *personal* responsibility was embedded in culture, structure and agents. Had this study been carried out more than two decades ago, the practice context would have looked very different, and Refining may have been less possible. From today's perspective, it instead draws attention to how over-reliance on Refining might constrain the possibility of other practice change, suggesting a key mechanism for it is:

- A culture of professionalism as a personal commitment

10.4 From 'What I Found' to 'What this Means'

This chapter closes Section II ('What I Found'). Having introduced the practical social theory of SSD practice change and key concepts for making sense of Section II in chapter 5, I explored each aspect of the practice context from participants' perspectives in chapters 6-9. In this chapter, I configured the six cases of practice change by showing how each aspect of the practice context contributed to their emergence. I then discussed how each case - Transforming, Redistributing, Venturing, Personalising, Delegating and Refining - came to be one way rather than another. To show how these cases could be transferred to other settings, I posited key mechanisms which would need to be invoked if that case was the desired outcome.

The findings of this case-based sociological inquiry underpinned by critical realism support Byrne's observation that:

> We as social scientists can deal with – to use the terminology – ensembles of systems. We can deal with lots of cases and see how the configurations they represent can help us to understand the various ways in which things have come to be as they are, the various ways in which they might be different, and – with luck and the wind in the right quarter – how social action might produce one possible future rather than another (Byrne 2005, p.101)

In Section III ('What this Means'), I will reflect on connections with previous scholarship and translate these findings into six practical propositions for using this research. I will also consider the possibilities for moving this research on to further projects, and reflect on the nature and extent of its contribution.

Section III: What this Means

11 What this means

Making sense of this thesis and its implications includes being clear about what it is not trying to do. There was no desire to change or guide participants' practice, or to evaluate practice change that had (or had not) happened (Nilsen 2015). There was no intention to test or refine existing middle-range theories, as in realist evaluation (Pawson and Tilley 1997), or to develop a small programme theory of change (Davidoff et al. 2015).

Instead, this thesis sought to provide a middle-range *adjunct* to such projects by offering basic sociological knowledge about how different patterns of work over time explained trajectories of practice change in one long-term jurisdiction of a particular profession. The theory of SSD practice change identifies six trajectories of practice change (cases) emerging from different patterns of work in four interdependent aspects of the practice context. Key mechanisms that would be necessary for the Transforming, Redistributing, Venturing, Personalising, Delegating and Refining cases to transfer are also proposed.

In sum, the practical social theory suggests that planning for implementation outcomes related to specialist speech and language therapy for children with SSD will be strengthened by taking account of the Intervention work, Candidacy work, Caseload work and Service work required. This theory was made possible by the rich resources of participants' insights, sociological theory, and research around SSD and speech and language therapy. Acknowledgements are threaded throughout the chapter, but in 11.1 I reflect on some of the biggest debts owed to previous scholarship.

The intended contribution of this thesis will, however, ultimately be judged by the extent to which it is of practical use. Making practical implications of research explicit is itself a methodological step, as one participant observed:

> …she liked 'Speech & Language Therapy in Practice' cos you'd already DONE the work?.. or were publishing.. articles where other people had done the work.. to make the leap from.. that journal ((points at copies of International Journal of Language & Communication Disorders on bookshelf)) to 'this is what it means'? You know, joining that dot thing?..

In 11.2, I will therefore translate the reported findings into six practical propositions for using this research. In 11.3, I will discuss the contribution of the thesis by reflecting on the extent to which my aspirations have been realised and what I still have to do. I will then consider possibilities for moving this research on (11.4), before concluding with an overarching assessment of what it means (11.5).

11.1 How findings relate to previous literature on the work of practice change

In chapter 1, I described how previous scholarship on the work of practice change intersected to form an implementation-practice-profession lens for this thesis. This created three assumptions about practice change in routine speech and language therapy for children with SSD:

- that interventions would be more or less discernible as part of practices nested within other practices
- the trajectory of practice change may depend on collective work to change the immediate practice context and / or architecture holding practice(s) in place
- there would be profession- and jurisdiction-specific features at play

In chapter 2, I set this lens within a social ontology and two explanatory frameworks, which also helped operationalise the study. As the practical social theory developed through interplay between theory and empirical work, four aspects of the practice context emerged as most explanatory for different trajectories of practice change: Intervention, Candidacy, Caseload, Service. In turn, as touched on in chapter 5, identifying these aspects prompted connections back to theory (Table 11-1) and other literature.

Table 11-1: Theoretical structure

Social Ontology	Explanatory frameworks	Theoretical sensitisation	Practical social theory
Critical realism	Morphogenetic Approach Complex interventions as layered parts and wholes	Implementation-practice-profession lens Candidacy theory Caseload literature	Theory of SSD practice change

11.1.1 Relating to implementation-practice-profession theory

Of the middle-range implementation-practice theories and frameworks discussed in chapter 1, Normalisation Process Theory (May and Finch 2009) and Practice and Practice Architectures (Kemmis et al. 2014) were particularly influential throughout.

Normalisation Process Theory (1.2.1.4) provided a way of thinking about agency in conditions of constraint that was indispensable to questioning, noticing and focusing discussion throughout data collection and analysis. Harnessing the core construct of Coherence (sense-making work), in particular the Differentiation component, brought a joint curiosity to unpacking the nature of routine SSD intervention and how this had changed or not. Considerable sense-making work went on within interviews as participants sought to articulate practice changes, and I sought to understand them by encouraging them to consider how this might be different from what they had done before or from other people's experiences. The components of Communal and Individual Specification differentiated the balance of support for Coherence provided within and across Services; noticing this was key to understanding why sense-making was more challenging for some participants than others.

The Legitimation component (part of Cognitive Participation) also proved important, as there were differences between therapists - and between therapists and their managers - in what was considered appropriate SSD practice change. This pattern carried over to Collective Action and the

component of Contextual Integration because participants were more or less constrained by the resources available to them as a consequence of what was considered appropriate. To use May et al.'s (2016) analogy, this helped differentiate cases of practice change as, for some, it gave greater elasticity to the intervention context (e.g. Redistributing case 10.3.2) while, for others, interventions had to become more plastic (e.g. Venturing case 10.3.3).

While Normalisation Process Theory was a powerful way of thinking about the work of practice change, Kemmis's Practice and Practice Architectures (1.2.2.1) and the idea of 'entrenched' practices (Montini and Graham 2015) provided more potent metaphors for visualising how practice is embedded and the work it might take to free it up for change. Kemmis's idea of 'sayings' in a 'semantic space' was particularly helpful in thinking through the words participants used to convey what they do and how this has changed, and how these words patterned. Semantic spaces in which participants were providing SSD intervention at the specialist level varied considerably, with some lacking the 'cultural-discursive arrangements' in their Service that would make changes at the theoretical layer of intervention a possibility. Even where individuals had access to richer semantic spaces outside of their service, for example via a clinical excellence network, it took a change in the semantic space within the service (e.g. Transforming case 10.3.1) for the possibilities to become easier to enact and harder to dismiss as irrelevant.

Appropriately for a study of the work of practice change, Practice and Practice Architectures also illuminated the influence of 'material-economic arrangements' as the 'doings' of practice in 'physical space-time'. This drew attention to the real and often unanticipated effects of changing the logistical layer of intervention (6.7), and the non-trivial role of Material (6.5.1). In-depth planning emerged as a necessary part of 'physical space-time' for practice change but, returning to Normalisation Process Theory, discussion with participants suggested a Legitimation issue. Framing the CLEAR assessment tool as part of the Candidacy Practice Architecture holding traditional intervention in place (7.2.3.1) is not only an example of 'doings' in 'physical space-time' but a specific illustration to highlight for collective critical reflection. As reasons for the CLEAR's popularity in this study are consistent with those

from the Child Talk research (Roulstone et al. 2015), the illustration is likely to resonate with therapists.

Although Practice and Practice Architectures also considers 'social-political arrangements', Abbott's (1988) notion of jurisdictions as occupied and interdependent presents a more compelling analogy for considering how development of the speech and language therapy profession as a whole and practice change in the specialist SSD jurisdiction might interact. It lends credence to the sociological questions raised by SSD literature (1.4.3) which point to multiple agential, cultural and structural reasons for the jurisdiction's practice change status relative to other jurisdictions. This again harks back to Legitimation, and the passion expressed by some participants that the SSD jurisdiction is more complex and core to identity than the profession acknowledges but has been overlooked through having to compete with jurisdictions perceived as more important, exciting or challenging.

As Gabbay and le May (2016) found with GPs, following the practice (1.2.2.3) into the immediate professional context just for the specialist SSD jurisdiction made visible the overwhelming complexity of speech and language therapy decision-making and competing expectations impacting on the trajectory of practice change. When Lau et al. (2016) overviewed reviews of change in general practice, they were frustrated by the preponderance of descriptive barriers and facilitators without intention to seek causes. Following the practice has provided empirical evidence of where it is possible for speech and language therapists working collectively to change practice *in context*. In addition to explicating this context, it has also provided clues back to theory and frameworks which may help them to make desired changes happen.

Returning to Normalisation Process Theory constructs, this study suggests that, while speech and language therapy managers have many competing priorities for practice change, their Cognitive Participation in the potential of the Intervention aspect and specialist knowledge dimension of Candidacy to improve effectiveness is necessary to protect and raise the credibility of the specialist SSD jurisdiction. The under-researched role of such 'middle managers', including team leaders, in creating expectations and supporting new

practices in organisations was explored recently through comparing sites with high and low change potential (Engle et al. 2017); the theoretical and empirical interplay made for highly practical findings about action in context.

NoMAD (Finch et al. 2015), a freely accessible 23 item survey associated with Normalisation Process Theory (1.2.1.4), would also support processes of Cognitive Participation, but this study suggests that PARiHS (1.2.1.1) may be particularly well suited to a speech and language therapy jurisdiction because it brings together 'evidence' in its widest sense (linking with professional body and intervention science initiatives), context (where the theory of SSD practice change is a potential adjunct) and facilitation (a suggested key mechanism in the Transforming case). The i-PARiHS tool may help operationalise facilitation (Harvey and Kitson 2016). Anecdotally, the Theoretical Domains Framework (1.2.1.2) appears to be gaining most traction in speech and language therapy's engagement with implementation science; while this is valuable, the limits of the Refining case (10.3.6) suggests the profession may benefit from theories which actively shift the emphasis from psychological to sociological theories with their focus on collective action and social mechanisms rather than individual effort.

11.1.2 Conceptual separation of Candidacy and Caseload

Candidacy and Caseload emerged in this study as conceptually separate explanatory aspects of the context for practice change, although the two were often experienced as conflated. A similar pattern can be seen in literature about occupational therapy for children (e.g. Kolehmainen et al. 2011), and may be appropriate depending on a project's goals. It may however also highlight a difference between a psychological behaviour change and a sociological orientation to enquiry; Kolehmainen et al. (2010) found associations between a child's length of time on the caseload and individual occupational therapists' practices of 'caseload management' which, in light of this study, would seem more akin to practices of '*case* management'. This tension was in the earliest version of the theory of SSD practice change, which featured 'Make-up of caseload' and 'Make-up of case(s)' (Figure 11-1), with the evolution to Caseload and Candidacy reflecting the more sociological perspective.

Figure 11-1: Early version of theory
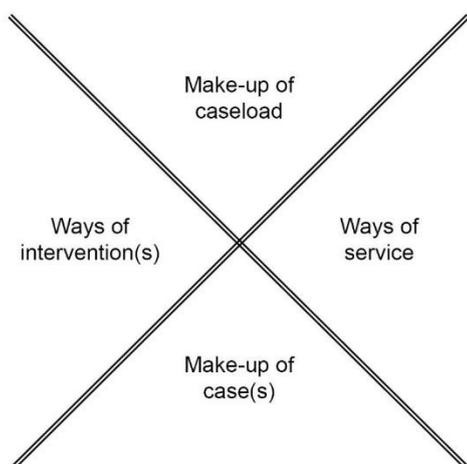
Another reason for conflation may be the widespread use of Care Aims which cuts across Candidacy and Caseload. Miller et al. (2013) for example reported on four quality improvement initiates in their service which together drew on Care Aims to address equity, family-centred care and waiting times in child occupational therapy case and caseload management. Similarly, through questionnaires with staff and interviews with three team managers, Stansfield and Matthews (2014) evaluated the introduction of Care Aims to an adult learning disability service and reported its perceived impact on referrals, caseload management and discharge. The following sections will explore why this study suggested that, for the purpose of explaining SSD practice change, conceptual separation was necessary.

11.1.3 Relating to Candidacy theory

The term 'candidacy' is not unknown in speech and language therapy. As discussed in a paper in the qualitative synthesis, in the AAC (alternative and augmentative communication) jurisdiction, the candidacy model refers to a discredited and outdated approach that restricts access to communication aids unless particular intellectual or sensorimotor skills are already evident (Iacono and Cameron 2009). Less controversially, Turner and Whitworth (2006) profiled what speech and language therapists considered made people high- or low-candidacy conversational partners for people with aphasia, then tested this in a single case study. Their idea was to target supportive strategies rather than to include or exclude people from the approach.

While these notions of candidacy hint at the ethical and contingent nature of decision-making around who has the right to start, continue with and end specialist involvement with speech and language therapy, Dixon Woods et al.'s (2006) construct of Candidacy offered greater theoretical coherence. Candidacy is a middle-range theoretical account of access to healthcare generated through a critical interpretive synthesis of existing empirical and theoretical evidence. It describes how eligibility is constantly negotiated and constructed, requiring considerable and socially patterned work on the part of users, in interaction with local conditions, resources and professional practices (Dixon Woods et al. 2006).

Extrapolation of the stages of Candidacy (Mackenzie et al. 2013) shows that this study was largely limited to the latter stages, where professionals adjudicate, offers of services are made and resisted, and candidacy is produced locally. With selectivity becoming more prevalent and questions remaining about existing service provision's ability to tackle inequalities (Mackenzie et al. 2013), and jurisdictional tension between universal, targeted and specialist levels, this is fertile ground for future research.

11.1.4 Relating to Caseload literature

Although common sense would suggest that caseloads impact on practice change, the emergence of Caseload as a key theoretical aspect in both the qualitative synthesis (3.5) and the empirical study (chapter 8) raises its profile. Within speech and language therapy academic literature, caseload has received little attention beyond acknowledgement that large caseloads are difficult to manage. One reason may be that meaningful comparison is challenging. Routine data across seven UK districts from October 1996-March 1997 was difficult to collect, and analysis found considerable variation in staffing ratios per 100,000 population and in the proportions of clients who were new, ongoing, on review or discharged during that period (van der Gaag et al. 1999).

Two caseload analyses in the speech and language therapy literature arose from studies which were not designed for that purpose, again suggesting it is important but under-theorised. A survey of 649 school-based speech-language

pathologists in the United States included background questions around caseload manageability (Katz et al. 2010). The mean caseload size was 49, and there was a steep upward trend in perceived manageability from 41, with 60% reporting caseloads of 56-60 as unmanageable. Logistic regression suggested further that therapists who had large caseloads, more years of experience and were expected to engage in newer practices found their caseloads less manageable (Katz et al. 2010). Kenny and Lincoln (2012) interviewed speech-language pathologists about ethical reasoning, and 16 of the 20 participants discussed caseload management. Analysis of the metaphors used drew attention to the energy and team spirit inherent in sports metaphors, and the survival and isolation conveyed by those of war. Metaphors of scales were particularly revealing of compromises around evidence-based practice, seen most notably in the Venturing (10.3.3) and Delegating (10.3.5) cases.

This thesis is congruent with these previous studies and, by considering how caseload contributes to trajectories of practice change, not only highlights ways that services might change their caseload practices but opens up theoretical links to caseload in other professions such as midwifery and health visiting. Forster et al. (2011), for example, showed how an early iteration of Normalisation Process Theory could help explain sustainability or otherwise of two midwifery service models for managing caseloads (small team and caseload) introduced via randomised controlled trials.

Corporate caseloads, implemented to different degrees as 'collapsed' caseloads by [Blaeshire] and its hubs, feature in health visiting literature, where the susceptibility of caseload models to gain traction in practice without critical evaluation has also been noted (Houston and Clifton 2000). The first independent study of the practice highlighted that "there appeared to be something within the new corporate structures" that stimulated collective improvements in transparency, support and record keeping (Hoskins et al. 2007, p.22). This chimed with reflections from the authors of a concept analysis who in their own service found most practice change emerged from weekly allocation meetings (Houston and Clifton 2000).

The findings of this study strongly suggest that a theoretically-informed systematic review of caseload across the helping professions literature would be informative. This could include midwifery, health visiting, social work, and other allied health professions.

11.2 Using this research

As the findings are multi-layered, they have the potential to be applied in a variety of ways. In deciding which of many possible propositions should have priority, I was guided by what provoked a 'that's interesting!' response (Davis 1971). Despite being embedded in the profession, and familiar with the problem of practice change, I only noticed what was going on sociologically through doing this research. If propositions struck me as intriguing, relevant and credible, I imagined they might also resonate with potential users - therapists, managers, researchers, educators and professional leaders.

The first two propositions (Figure 11-2) refer to the main outcomes of this research: the theory of SSD practice change, and the SSD intervention change model. The next two build on findings about how attending to social structure might support SSD practice change, while the final two propositions relate to influencing the culture for it.

Figure 11-2: Practical propositions for using this research
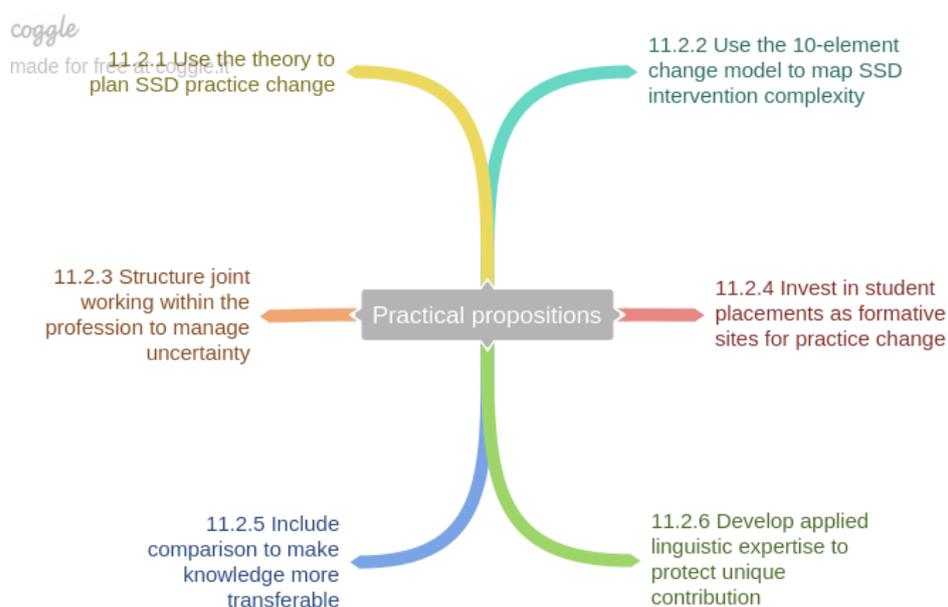
11.2.1 Use the theory to plan SSD practice change

If we frame any deliberate effort to support practice change as intervention in a pre-existing context, it becomes vital to understand not just the desired change but the particular context and, if necessary, how it could be modified. Considering all four aspects of the practice context - Intervention, Candidacy, Caseload, Service - will not predict success or failure of intended practice change. However, as the cases and practice context were derived from rigorous research in real clinical settings, the first proposition is that referring to the theory of SSD practice change (Figure 5-1 reproduced below) should make *anticipation* more robust.
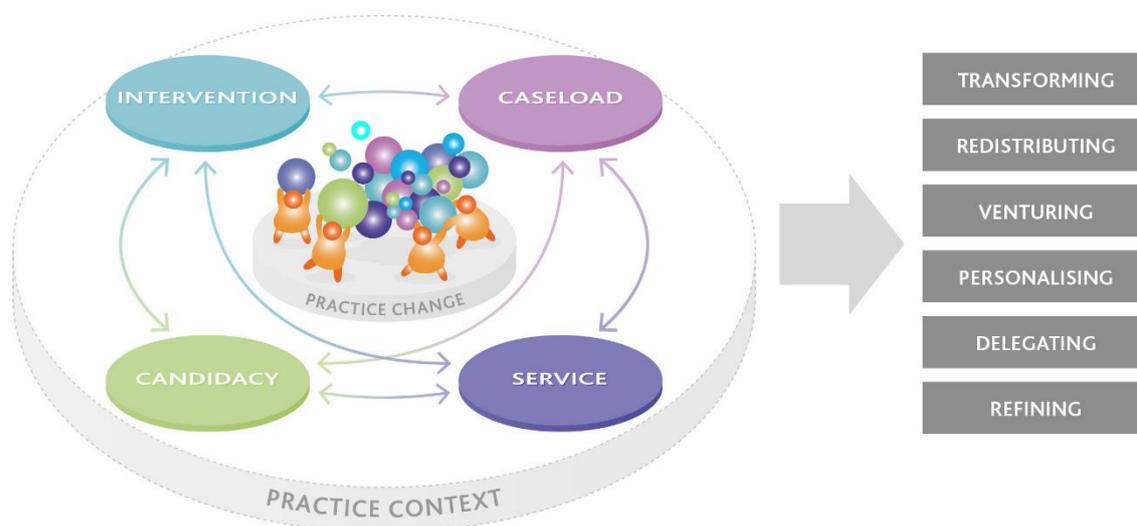
The most direct use is for clinical services planning any practice change that has implications for SSD intervention at the specialist level. Considering all four aspects of the practice context in an integrated way means asking questions such as:

- Of all the practice changes we would like to see, what are our priorities, and how do these fit with each aspect of the practice context?
- How ready are we for the type of practice change we want to see? What doesn't need to change? In other words, what is already in place that will provide a platform for this type of change?

- What do we still need to invest in each aspect of the practice context to make this practice change possible? What order do things need to be done in, who needs to do it, and how long is this likely to take?

- What implications will this plan have for our other projects? What conflicts might it produce between aspects of the practice context, and what will we do about that?

Such an approach demands collective work as described by Normalisation Process Theory (sense-making, operational, appraisal), which could have an impact on staff's cognitive participation for the practice change (initiation, enrolment, legitimation and activation) (May 2013). It could also help services be more transparent about what they do and do not offer.

In addition, educators could use the proposed practice context for SSD practice change to help students understand the complexities and contingencies of the work. The professional body could use it as part of service benchmarking. Intervention researchers could use it to support development of implementation tips, while trialists could use it as part of modelling what constitutes 'usual care', a particular knowledge gap (Fletcher et al. 2016).

In its current form, the theory is an idea rather than a tool; this offers flexibility but might limit uptake. To justify developing it as a functional tool, its transferability to other client groups (beyond the specialist level of SSD), beyond Scotland, and potentially beyond speech and language therapy would need to be investigated, and potential users involved in the design and evaluation.

11.2.2 Use the 10-element change model to map SSD intervention complexity

The second proposition is that, through deepening reflection on real-world intervention content and flexibility, the 10-element model of SSD intervention change could help map and explain its complexity. I hope it will be useful in pre-qualification teaching, personal or collective reflective practice, continuing professional development, service evaluation and research. Developing an intervention change model was not an a priori aim of this research (2.3.3), but grew out of fieldwork. It represents what *existed* in SSD intervention, whether or

not participants actively noticed or selected all elements as components (Figure 6-1, reproduced below).
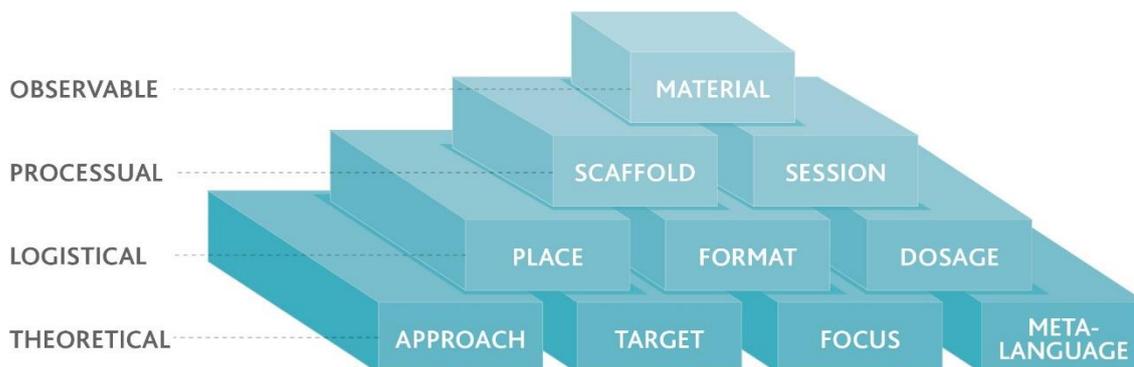
Although available for testing and refinement, I suspect the model's practical value will come less from efforts to improve it as an outcome than from the process of using it. The model's potential lies in explicating the relationship between what exists in SSD intervention and what actually happens. Through mapping this relationship, patterns such as preferred elements, possible combinations, unvarying choices or silent elements can be noticed, and possible reasons discussed. In making this aspect of practice architecture (1.2.2.1) visible, the model also provides a template structure to support observation, reporting, and comparison across time, interventions or people.

As it was constructed from real-world practice, the model offers an opportunity to improve knowledge exchange between research and practice. Consider, for example, the findings of a newly published review of randomised controlled trial reports in the speech and language therapy literature. Ludemann et al. (2017) mapped intervention description to the TIDieR (Template for Intervention Description and Replication) checklist (Hoffmann et al. 2014). From 129 articles (162 interventions), none were completely described from primary or secondary sources, and only 28% after correspondence with authors. Information about tailoring, modification, materials and access to materials were least well reported. Ludemann et al. concluded the lack of detail would limit therapists' ability to use the reported interventions.

The layered SSD intervention model may help researchers appreciate what they need to include (such as sample session plans) to make intervention not just more replicable but more *implementable*. In addition, including all elements

of the model in a manual whether or not these are components of the intervention would reduce therapists' uncertainty over where they have more or less room for flexibility and improvisation. This suggestion fits with a recent exploration of TIDieR beyond intervention description in randomised trials which included a recommendation to record 'modification' of every item (Cotterill et al. 2018).

The model may also help improve the relevance of SSD randomised controlled trials which include a usual or standard care arm. In such trials in any healthcare field, usual care is often given cursory attention even though intervention components can overlap and interact with other intervention arms and be equally as complex (Erlen et al. 2015). The model could help qualitative researchers map and describe usual care interventions as part of a feasibility study, which would feed into decision-making about proceeding to a full trial.

11.2.3 Structure joint working within the profession to manage uncertainty

By taking a sociological approach, I hoped to discover how and why the social was important for SSD practice change, and joint working with other speech and language therapists appeared to make a difference. However, the research also confirmed services are under pressure, policy is directed towards interdisciplinary work, and unrealistic demands from researchers alienate practitioners; proposing more joint working within the profession therefore risks provoking a 'that's absurd!' response (Davis 1971).

Nevertheless, the benefits of joint working with other speech and language therapists was apparent in the managerial commitment to it, and the difference it made in all four aspects of the practice context. For Caseload and Service aspects, some managers encouraged decision-making and project work in mixed band hubs. In [Blaeshire] there was an additional commitment in each aspect to external and internal facilitation. For Candidacy decisions, [Blaeshire] had joint assessment clinics with two therapists, while Triage in divisions of [Staneshire] and [Clootshire] had included degrees of joint working. Where participants were new to these opportunities, they discussed the impact with warmth and surprise.

For Intervention, *direct* joint working was restricted to student placements, groups and one example of session observation. This was ameliorated by collective *indirect* activity, such as joint attendance at training events with credible knowledge brokers, joint planning of follow-up action, and participation in email groups and social media. Internal service discussion around the Communication Trust's What Works database[42] of experimentally-evaluated interventions was supported and, in [Blaeshire], internal facilitated training included hub-based reading, discussion and development.

Historically, community speech and language therapists have done their *work* in isolation from colleagues, even if they have social ties. This appears to have fostered considerable autonomy and self-reliance, while generating a mystique around practice. Almost overwhelming uncertainty is created if the confusing "smorgasbord of approaches" (Baker 2006, p.156) available for SSD Intervention compounds other demands in the Candidacy, Caseload and Service aspects of the practice context. My findings suggest facilitated opportunities for direct joint working in all aspects of the practice context, including Intervention, may ultimately provide a more efficient way of navigating through uncertainty to successful implementation.

11.2.4 Invest in student placements as formative sites for practice change
The fourth proposition is to invest in student placements, not just as formative sites for practice, but as formative sites for practice *change*. This takes account of three considerations. Firstly, learning there are choices around SSD intervention had come as a surprise and even an embarrassment to many [Blaeshire] participants. They wondered how it was possible for them and their colleagues to have remained unaware, particularly as these choices had been in the literature for well over a decade. Secondly, from university lectures, a clinical academic colleague, or Caroline Bowen's website, a few individuals had some awareness of choice around SSD intervention, but had not acted on it. The small number who had engaged proactively as individuals did so either directly through repeated attendance at Caroline Bowen's courses, or indirectly

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[42] Although none mentioned how they became aware of What Works, it had been promoted by Royal College of Speech & Language Therapists networks, including a video-linked study day across Scotland

following formative (and what they suggested was unusual) research placements. Thirdly, persistent effort was needed to tip [Blaeshire] into adopting non-traditional SSD interventions, and one hub in particular emphasised their responsibility to support students to use them.

These considerations suggest usual practice, training and placement models were insufficient to transform SSD intervention because 'choice' (agency) existed in theory but not in practice. No-one had heard or seen non-traditional approaches discussed or used in routine settings, nor did they encounter anyone who had. Entrenched lack of diversity in the Intervention context may have been masked by the internal diversity of SSD interventions, and by limited clinical and academic integration.

Other than changing job, student placements may therefore be the only career opportunity speech and language therapists have to experience and compare different practice. Practice education is already demanding and time-consuming for therapists, and universities are expected to teach an ever-widening curriculum with fewer resources. However, in addition to the [Blaeshire] model, this study offers two possible routes to investing in placements as formative sites for practice change.

The first route is indirect. One participant tried out a non-traditional SSD intervention in conjunction with a student following a practice educators' day and engaging with the What Works intervention database as part of a local clinical network. Others attended a Clinical Excellence Network as part of a group who committed to action and collective review. One route is therefore to support existing *groups* (rather than individuals) to participate in SSD Clinical Excellence Networks, including a focus on interventions-in-practice, with the committee and members committed to integrating clinical and academic contributions.

The second route is methodological. Students are already encouraged to reflect on their placement learning, and to provide evaluative feedback on their practice education. Perhaps they could also be supported to compare and contrast placement experiences from a workplace sociology perspective, to prepare them to address cultural and structural realities. However, as this meta-

level of reflexivity may prove too demanding to be useful, it would have to be carefully tested.

11.2.5 Include comparison to make knowledge more transferable

Realist sampling for the qualitative synthesis showed illustrative case examples helped speech and language therapists talk about their practice (3.3.4). 'Case study' is also a popular tool for knowledge exchange. The Communication Trust's online What Works database of interventions (widely cited by participants) includes case studies where therapists describe how they put the particular intervention into practice. Helpful template headings cover context (where), people (roles), practicalities, outcomes, and top tips. This fifth proposition is that even more useful and transferable knowledge may be generated if a *comparative* element is included.

The idea of including a comparative element started with an interviewee's story about how, instead of an intended case study to reflect on implementation of Multiple Oppositions, a consultant therapist encouraged and supported her to construct a before-and-after comparison of decision-making. The interviewee was concerned to convey the value of the facilitation, particularly with linguistic aspects. However, her story drew my attention to the implications of a difference between a case study and comparative decision-making approach, perhaps because this study also depended on comparative methods (4.1.1).

Through *comparing* decisions, the interviewee appreciated all the points of difference from the traditional approach she would have used before. She went on to support other therapists with implementation, possibly more aware of potential uncertainties or misunderstandings than she would have been through a case study. Managers' comments on the hidden nature of clinical practice are also relevant. In [Blaeshire] they addressed this by encouraging transparency around decision-making through peer supervision and collapsed caseloads, both of which have comparative elements. Another manager wanted to use case discussion for group learning but, on presenting a case outline, found staff were not 'ready' to expose themselves in this way.

In considering why comparative decision-making might be an effective alternative or addition to a case study approach for reflective practice, there are

at least three possibilities. First, thinking about alternative pathways rather than right or wrong might depersonalise the process, making it more objective to discuss. Second, the complexity of decisions - and number of points of divergence - is likely to be clearer when comparison is used, helping people to sort out layers of complexity and fine differences. Third, comparing decisions draws attention to a therapist's agency to do things differently, and may also highlight where structural and cultural barriers exist.

It could be argued that case studies make clients the central focus, and that focusing on therapists' decision-making risks silencing them. However, therapists learn from working with a range of clients. For shared decision-making to take place with individuals, therapists have to be aware of possible choices and able to make them transparent.

11.2.6 Develop applied linguistic expertise to protect unique contribution
The final proposition to develop applied linguistic expertise recalls Abbott's idea of jurisdictions, where incumbent professions defend their territory (1.2.3). It invokes a participant's use of 'protect', an emotive word signalling an imperative to act against a perceived threat. It not only claims applied linguistic expertise, but declares this both unique and worthy of protection.

Consider that, while contemporary therapy rightly involved giving territory away, this option was more limited for SSD than other jurisdictions. Caseloads included children with speech, language, communication and eating/drinking needs. Believing communication is everyone's business, participants took responsibility for building capacity of parents and other professionals to manage most children in everyday settings. Even at the specialist level, they could not be effective without support from others around the child, but none of this removed their felt primary responsibility for SSD, particularly when the impairment was severe and persistent.

However, over time, effectiveness had stagnated as SSD became taken for granted during rapid advance into jurisdictions such as autism and universal services. Neglect of SSD manifested in the removal of clinic-based sessions, reduced agency to offer direct or weekly therapy, and lack of agency to increase intensity. Individuals who raised the need for reflection, audit or

training around SSD intervention encountered complacency. Improvement in the majority of children presenting with SSD made it possible for therapists to increase universal and targeted efforts, while also accepting slow progress in others was beyond their influence.

This complacency was disrupted when investment in applied linguistic expertise made a difference more quickly to some children previously expected to remain on the caseload for years. Flexibility to increase Dosage achieved this to a degree. However, the chance to develop and apply linguistic expertise was often more rewarding and stimulating, in spite - or perhaps because of - the intellectual challenge. Even some less enthused by linguistically-driven approaches saw the opportunity they offered to protect direct intervention, the reason they had come into the profession.

As the profession learns to cohabit jurisdictions, this study suggests it should also consider delimiting exceptions. NHS cuts, combined with historical neglect and complacency, risk an SSD vacancy. Given SSD work has some protection through professional title and knowledge brokers such as Caroline Bowen, the rapidly expanding cohort of private speech and language therapists (particularly in England) is well placed to move in where families choose and can afford to pay. We have to decide if this is acceptable when the unique applied linguistic expertise of speech and language therapists makes us potentially more capable than any other professional group of making a difference to children at risk of severe, persistent and disabling SSD.

Pushed further, my analysis suggests SSD's association with applied linguistics means threats to that jurisdiction constitute a threat to speech and language therapy's identity. If we vacate SSD at the specialist level, who are we? What will happen to our unique applied linguistic expertise, with what implications for other client groups?

11.3 Contributing to knowledge

The task of this thesis was to explore, understand and explain practice change in a speech and language therapy jurisdiction, children with SSD. With that task tackled and practical propositions put forward, in this section I will consider the

validity of this work before judging the extent to which the five intended contributions have been realised and what I have still to do (Figure 11-3).

Figure 11-3: Judging the contribution of this thesis
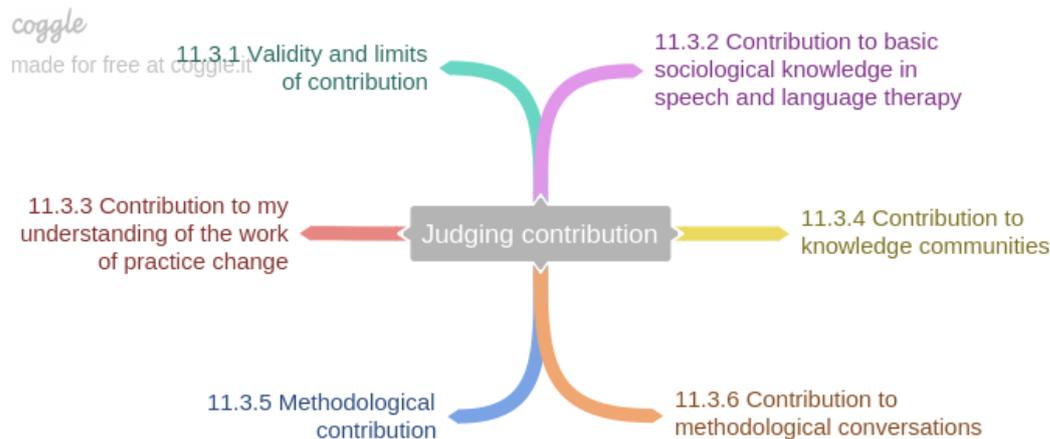
11.3.1 Validity and limits of contribution

If we accept reality exists but can never be fully known (2.2.1), the validity of any research is a relative judgement about the *implications* of its design and conduct. With the underpinning question 'Where might I be wrong?' (Figure 4-9) I anticipated and looked for threats to validity throughout to guard against or address them. In reporting, I have tried to make my judgements transparent, so users can decide whether - for their purposes - these were appropriate or sufficient. In addition to the detailed example (4.5) of how I decided it was valid to stop interviewing at 42 participants, in this section I aim to offer:

> a considered argument about the sources of uncertainty in the research and what they mean for how a particular knowledge contribution should be taken up by others (Lingard 2015, p.137)

While from some standpoints strengths and limitations are inherent in methods, from a critical realist perspective that judgement is always relative and contingent. Here, the possibility of valid findings depended on the success of sampling, which in turn depended on accuracy of prior assumptions. These included data availability (that practice changes would have occurred, would have a degree of patterning, and once categorised and connected would help

to explain different outcomes (2.4)) and data accessibility and depth (trusting participants to have and tell their stories of practice change (2.4.1)). From this platform, I would argue I enhanced validity by stepping back from evidence-based practice as an explanatory framework, and using four underpinning questions (Figure 4-9) and comparison (4.1.1) throughout.

With this in mind, reasonable challenges to this study's validity might include: was a participant-centred approach more valid than a method-driven one? Did sampling people with *actual* connections make findings more transferable or too particular? Did explicit working with theory act more as a scaffold or a cage? Would a longitudinal design or participant observation have offered more relevant insights than single stage interviews and focus groups? Did the sociological approach deliver sociological knowledge? To what extent did I make my insider-outsider status work for or against validity (Figure 1-1)?

Limitations of this research arose from interrelated consequences of knowledge boundaries, methodological decisions, and available resources. Some could have been addressed given more time. For example, I identified the potential relevance of identity, and the value that might have been added by including speech and language therapy assistants, and had also hoped to return to participants before completion to learn more from discussing the findings.

Two other limitations were more inherent consequences of efforts to balance breadth, depth and scope of the design. First, to build sufficient similarities and connections into the study, I only sampled from Scotland, accepting that transferability of findings would be limited by different policy, cultural and geographical contexts. However, the possible specificity of Scottish SSD practice also became apparent. Colour Coding and Metaphon broke new ground in applied linguistics; both originated in Scotland and were linked by an influential clinical academic. It is possible this helped embed the idea of minimal pairs and Meta-language in Scottish practice in a way that would not be found to the same extent elsewhere, and that this made a difference to which other interventions were more or less likely to find favour.

Second, although power was not key to the explanatory framework of this study, it is reasonable to wonder if some decisions masked or reinforced power

inequalities that are relevant to practice change. Having been a user representative in both practice and research contexts, I felt it was unethical and counterproductive to include such stakeholders merely to tick a box. Including them meaningfully would have changed the scope and nature of the research questions. Pursuing comparisons with other professions, other speech and language therapy jurisdictions, or universal or targeted levels, would also have increased breadth at the expense of depth. To mitigate potential negative effects of these choices, I emphasised repeatedly that I was not evaluating practice or services, and paid particular attention to how participants referred to children and parents, other professionals and other jurisdictions. I also deliberately introduced a critical lens via Abbott's theory (1.2.3).

11.3.2 Contribution to basic sociological knowledge in speech and language therapy

In 1.2, I outlined the need for basic sociological research in speech and language therapy to explain how practice had come to be as it was, and how open it may be to further change. Ideally this would offer a foundation of evidence around the dynamic social processes of practice change that could feed into pre-qualification teaching, improvement or evaluation projects, and intervention and implementation research. The challenge was to remain practical while becoming more theoretical; to make connections that depended less on simplification and consensus than on complexity and diversity; and to focus on SSD without losing sight of jurisdictional interdependence.

Researching practice change in a useful way is challenging. For years, researchers focused on speech and language therapists' uptake of 'evidence-based practice'. This has been superseded by a plethora of jurisdiction-specific surveys to establish what therapists do, accompanied by efforts to provide accessible research summaries and encourage reflective practice. Both the narrative review of what speech and language therapists do with children with SSD (1.5) and the qualitative synthesis (3.4.2) suggested 'evidence-based practice' continues to frame contemporary research. The original contribution of this research was enabled by moving the explanatory framework outwards to what was really going on sociologically, as this made important but poorly understood aspects of practice change visible.

Within the SSD jurisdiction, long-term involvement of the same researchers (such as Sue Roulstone and Sharynne McLeod), the use of similar or repeated surveys, and more recent mixed method studies have given a patchwork of snapshots. These indicate how *variables* related to practice - assessment, interventions, service delivery models - are shifting at a speech and language therapy population level. This research complements these studies and adds original explanation because it identified and reported practice change as an *integrated* activity, retaining the connections between practice and its context.

The problem of context bedevils researchers (see for example Bate et al. 2014). Rather than listing contextual variables, this research is particularly original in detailing what the key aspects of context *were* in relation to SSD practice change: Candidacy, Caseload, Service and Intervention. As the different trajectories of practice change were dependent on what was happening in all four aspects, it confirmed implementation as multi-faceted. More importantly, by tracking back to how practice had been, it showed empirically that this practice context is modifiable.

This basic sociological evidence did not exist before, and has the potential to be used by a range of people for a variety of purposes if I can make it accessible (11.3.4). While the theory of SSD practice change is not predictive, it identifies patterns that may be helpful in anticipating and planning for practice change. It is based on the realities of practice in three NHS areas and private practice in Scotland in 2015-2016. However, long-term relevance is unclear because the healthcare context is changing so rapidly.

11.3.3 Contribution to my understanding of the work of practice change

My curiosity about practice change has evolved over 30+ years as a therapist, magazine editor and maternity campaigner (1.3.3). As a therapist I juggled caseloads, cases and equipment across venues and multidisciplinary teams, trying to keep waiting lists down and paperwork up-to-date while developing the service and my practice. As an editor, I encouraged therapists to share the often mundane detail of their work, abstracting what was transferable to other client groups and contexts into 'read this if…' and 'reflections', and synthesising conferences and contemporary topics. As a campaigner I mediated the

perspectives of practitioners, policy-makers, researchers and women to facilitate practice change. I frequently despaired over the lack of understanding between groups, and wondered how this could be reduced.

It is reasonable to ask why this should matter for an academic thesis but, as critical realism recognises, people have concerns in relation to the world, and agency to act on these to shape society. Rather than a standalone work, this thesis is part of an ongoing project. To make it worthwhile, it had to enable me to take what I had done before to a new level. I particularly wanted to explore the potential of sociology to scaffold a different way of understanding the world, as the pull of psychology in speech and language therapy is strong.

The biggest surprise was coming round to the idea of interventions as things with properties. I think I had conceptualised intervention as a process not usefully (morally?) detachable from people and relationships. I found the reduction of clinical practice to components of complex interventions almost offensive, perhaps because it appeared to devalue the personal effort of being a therapist. Critical realism's separation of ontology from epistemology made it possible to see that elements of interventions existed, whether or not the therapists interviewed chose them as components.

Perhaps inevitably, researching practice in one context heightens awareness in others, and parallels between speech and language therapy and research were striking. Both demand considerable self-reliance, intellectual and relational flexibility, and tolerance of uncertainty, while facing ever-growing demands for evidence of effectiveness. Throughout this study I was able to apply learning about practice change to my research context, individually through close attention to the nature of the work, and collectively through facilitating groups on implementation science, qualitative analysis and critical appraisal.

This basic research was not intended to evaluate or change practice, but to provide a platform for others to apply. To test whether it could work, I thought about what I would want to do differently if I returned to clinical practice. In addition to the collective, facilitated activity in the previous paragraph, I would want to take on fewer children and discharge them earlier, take more account of parents' priorities in deciding if the time was right for intervention, and draw on

a wider range of approaches. I would hope to do more in-depth linguistic assessment, with more baseline and outcome measures, be bolder with target selection, and focused on generalisation from the start. I would also want to be more critical of decisions, acknowledging what was not being done as a consequence, and paying attention to potential harms of intervention as well as benefits.

11.3.4 Contribution to knowledge communities

There is little point claiming a contribution to knowledge unless it shifts the distribution of ideas in a knowledge community. Post-interview, one manager reflected on the knowledge the study must have amassed and my responsibility to share it. This study offers evidence that practice change in real-world speech and language therapy is a highly complex social activity which is nonetheless open to influence. The knowledge contribution has four dimensions: changeable elements of SSD interventions; the 4-aspect practice context; the cases of practice change; and practical recommendations. As these provide platforms for debate, the next step is enabling conversations about them to happen.

While planning this research I met Scottish speech and language therapy managers, observed a service's SSD training event, and curated and blogged a Twitter @WeSpeechies week on practice change. Although disappointed not to maintain this profile, lack of time was not the only reason. Uncertainty about what and how much to discuss while immersed in fieldwork and analysis, and how to act on any response, made me cautious. This caution made sense once I realised this was basic rather than applied research. Researchers are rightly expected to engage widely, but the type and timing needs to be appropriate for the study.

A Royal College of Speech & Language Therapists' Research Champions day was an opportunity to develop the analysis and communicate findings to therapists with a research interest or clinical academic role. The ethnographic monologues idea emerged while preparing for this event (4.4.4). I wanted the complexity of participant's perspectives to resonate, but the reference to 6-8 week intervention blocks provoked laughter, so may have reinforced rather than

challenged assumptions in this particular group. In future I could adapt the monologues to the audience, and prepare them to notice and reflect on their reactions, for example, an urge to laugh, roll their eyes, or nod.

Contributing to a knowledge community is a long-term commitment, much of it dependent on voluntary labour. I have offered to discuss the findings with participating departments and will present on the Transforming case and the SSD intervention change model at the Royal College of Speech & Language Therapists' conference in September 2017. I will reprise the @WeSpeechies week on practice change and prepare articles for journals and practice magazines. I also hope to liaise with SSD knowledge brokers, present at the recently formed Scottish Clinical Excellence Network for Speech Sound Disorders, and feed in to relevant professional body projects.

An ongoing challenge of introducing this research to relevant knowledge communities is explaining what it is about and where it might best fit into existing categorisations. For example, to what extent is it about practice change and complex interventions, or about SSD? Although I see it more as the former, my presentations at the forthcoming conference have been placed in 'child speech'. Meanwhile a survey of SSD practice is in 'service delivery' and another about evidence-based practice in routine clinical work is in 'creating and using evidence', both sessions which span client groups.

11.3.5 Methodological contribution

Explaining change sociologically through contrasting past and current practice has a long history in medical sociology. As this thesis continues a case-based empirical inquiry tradition using comparative methods, methodological originality comes in its application. Mapping connected therapist's perspectives on practice and change in a jurisdiction enabled identification of intervention elements and key aspects of context. The significance was learning not only that particular combinations had implications for the trajectory of change, but that each element and contextual aspect was modifiable.

Using critical realism as a meta-theoretical framework is also not new, and the counterfactual question - how this thesis would be different with an alternative framing - cannot be answered. However, in making connections, decisions and

consequences visible throughout, I offer a worked example of how critical realism might shape differences in the design and conduct of empirical inquiry that make a difference to the findings and potential impact. This effort to be honest about the reality and fallibility of research is not without risk; it actively invites critique at every stage, which may distract from the narrative thread.

Original methodological contributions are made by connecting disciplines, approaches or methods in unfamiliar ways. This thesis connected the academic discipline of sociology with the hybrid field of speech and language therapy, routine practice with qualitative methods, and implementation with intervention research. As a consequence, the findings retained the contextual complexity of clinical practice rather than separating it into variables such as 'service delivery' or 'assessment'. A new combination of realist sampling with meta-ethnography informed the primary study methodology as well as the practical social theory, and sensitivity to communication gave credence to transcription as an important methodological step.

While commissioning a study logo is not original, here it was also a theoretical starting point. A psychology colleague was horrified, seeing it as telling participants what to think. This reaction is intriguing, as it suggests study framing and assumptions are usually more implicit. I used the logo to frame and communicate an abstract problem (practice change as a complex social activity) without specifying processes or outcomes; informal feedback suggested it achieved this. The logo appeared on study literature and presentations, and was adapted to represent the four aspects of practice context in the theory of SSD practice change (Figure 11-4).

Figure 11-4: Logo at start and end of study
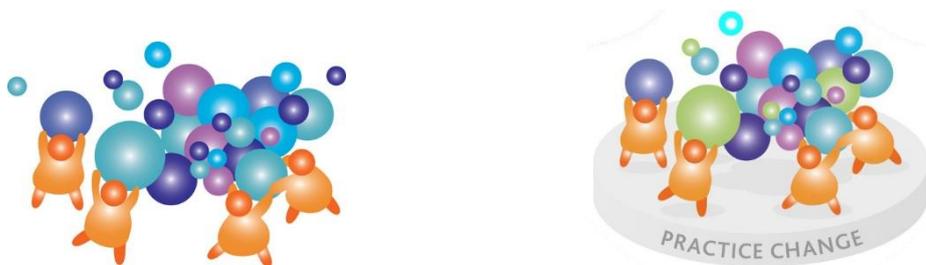
A methodological contribution may only become apparent when it produces surprises. Previous studies have noted speech and language therapists' difficulties in reflecting on their practice, with a tendency to focus on activities and materials rather than underlying theory. This was not my experience. While this could reflect different expectations, interviewer styles or samples, I suspect asking how practice had *changed* provided a scaffold. A second surprise was the extent to which asking about practice change shone a light on usual care; this has unanticipated implications for applied healthcare research.

11.3.6 Contribution to methodological conversations

Development of research methodology and practice depends on formal and informal dialogue in a variety of media to shift the distribution of ideas in research communities. Joining pre-existing conversations or starting new ones about research is an active process that takes patience, judgement and perseverance. Here, I will consider how I have begun to contribute to methodological conversations beyond my immediate research environment as a result of this thesis, and how I hope to build on this.

Methodology events are tailor-made for such conversations. I introduced realist sampling for a meta-ethnography at a British Sociological Association Applied Qualitative Health Research Symposium. An attendee who has published on reporting qualitative syntheses (Tong et al. 2012) urged me to write it up, as sampling in meta-ethnography is a methodological gap. Subsequently a synthesis methodologist asked via Twitter for my slides, gave feedback, and also advised me to publish. At the Realism Leeds PhD and early career researcher event I presented the transcription reporting analysis (4.3.2) in Pecha Kucha format[43]. In subsequent informal conversations, attendees reflected on transcription dilemmas, and how little they had considered aspects such as the transcriber.

Social media has helped me observe, understand and occasionally join methodological conversations, in particular via Twitter and the RAMESES[44] realist email group. Consequences are unpredictable. I tweeted a link to a blog

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[43] Available to view at https://www.youtube.com/watch?v=iuAuOt220H8
[44] Realist and Meta-narrative Evidence Synthesis: Evolving Standards

on cognitive coaching interviews, noting its relevance to qualitative interviewing choices. The blogger was inspired to write a further post on research interviews[45], to which I responded with a detailed reflection. Reach is also unpredictable, and often unknown. Following a workshop with Mark Carrigan and Margaret Archer, I blogged on making sense of ontology and sociological concepts; through Twitter and reblogging, there were 99 views within a month (Nicoll 2015).

Methodological conversations within the allied health professions need care, as qualitative methods have lower status and familiarity than experimental ones. Historically, research curiosity has related to impairments, with methodological development a secondary consideration. I contributed to new Royal College of Speech & Language Therapists' web pages on qualitative research and reviewed a paper on using theory in improvement (Davidoff et al. 2015) for its Bulletin. At the North East Scotland Council for Allied Health Professions Research symposium, I used sampling ladders (Figure 4-2), narrative threads (4.4.4) and models of intervention elements (Figure 6-1) to exemplify how qualitative research can enhance knowledge of practice. Informal feedback suggested the complex intervention model was of particular interest.

Although methodological work attracts limited funding and interest, my interest in practice change makes it inevitable that I will want to take this forward (11.4). I have been asked to record a podcast on the ethnodramatic monologues for the Stirling University MRes (Healthcare), plan to tweet and blog as time allows, and hope to submit papers on several methodological aspects of this thesis.

11.4 Moving this research on

Part of the contribution of this thesis is identifying priorities for further research that would be feasible as well as worthwhile. In addition to using a similar approach in other practice contexts, and suggestions around Candidacy (11.1.3) and Caseload (11.1.4), ideas which could be worked up as research

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[45] https://theeduflaneuse.com/2016/01/31/coaching-in-qualitative-interviews/

proposals relate to routine data, intervention content, sociological theory, and methods (Figure 11-5).

Figure 11-5: How I propose to move this research on
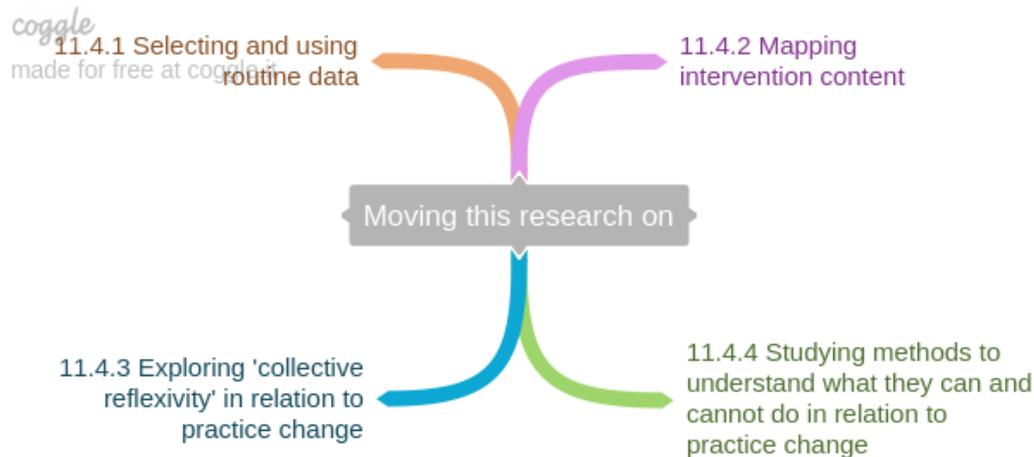
11.4.1 Selecting and using routine data

This research was not designed to seek or provide evidence of effectiveness or cost-effectiveness of SSD intervention. It did however draw attention to the *circumstances* under which analysis of routinely collected data might offer relevant insights. This is important because making better use of pre-existing data to improve healthcare is a strategic research priority (see for example Michie et al. 2017).

Although participants discussed practice changes in a way that suggested the underlying point was to improve outcomes related to effectiveness and cost-effectiveness, attempts to define and measure this systematically were limited. In [Staneshire], for example, participants perceived that parent groups for children with SSD were largely ineffective in changing children's speech. However, it is unlikely the data collected could support or challenge this because it related to process and satisfaction. In contrast, several [Blaeshire] participants referred to a generally shorter duration of intervention and faster change in speech following their SSD initiative, and believed this perception would be testable through examination of routine data.

My findings also suggest analysis of [Blaeshire]'s routine data would be particularly robust in relation to effectiveness because it would compare

intervention outcomes with minimal noise from the rest of the practice context. In [Blaeshire], the SSD initiative was preceded by major changes in the Service, Candidacy and Caseload aspects, which helped explain why it led to transformed Intervention practice. However, as routine data are created for other purposes, inductive qualitative methods would be essential to explore the scope and limits of the data and construct a research question and statistical analysis plan. This would leave room for unanticipated possibilities such as comparison of case file sizes and shifts in ordering patterns for Material, both of which helped one participant notice how practice had changed across her hub.

11.4.2 Mapping intervention content

As discussed in 11.2.2, Tammy Hoffmann developed TIDieR to improve description of interventions in research reports so they would be more replicable (Hoffmann et al. 2014). However, even if all sections were complete, the burden would be on therapists to make sense of researched interventions in their own setting because TIDieR is descriptive and de-contextualised. In giving a shape and depth to what exists in practice, a layered intervention change model such as the one developed in this study exposes what components are actively used, modified, combined or held constant.

In 1.3.2, I referred to Stokes and McCormick's (2015) struggle to teach speech and language therapy students what intervention is, given it is under-theorised, depends on improvisation, and is hard to evidence. This study used one highly inductive route to identifying elements of intervention through interviews and focus groups about practice change. Other sources such as case notes, documents, or previous qualitative data may be available or more appropriate / efficient for a similar study in other jurisdictions, and interacting with complex intervention work outside speech and language therapy also has the potential for mutual benefit.

The burgeoning and methodologically pluralist field of evidence synthesis, for example, offers guidance on intervention description which can generate knowledge about key components of intervention. Promising methods include Intervention Component Analysis (Sutcliffe et al. 2015) and Qualitative Comparative Analysis (Thomas et al. 2014). The psychotherapeutic literature

could be investigated, as intervention complexity is likely to be similar to speech and language therapy, and Kelley et al.'s (2010) paper on using a 25-item clinician self-report measure of session content and other usual care measures would provide a useful starting point for planning a research question and systematic review protocol.

11.4.3 Exploring collective reflexivity in relation to practice change

Doing this research has involved trying to access, apply and communicate debates and concepts from philosophical and sociological fields; in other words to make them practical for my purposes. As I had not done this before, the process of working through to a practical social theory was characterised by considerable tentativeness and fear as well as curiosity. Learning what can be done through doing it makes other ideas now seem more doable.

As an example for future consideration, this research confirms speech and language therapy as highly social work. Opportunities to work jointly with other speech and language therapists were enlightening and rewarding. It was important to all managers to enable exchange of ideas between mixed groups of staff, and a culture of facilitation was a key mechanism in the Transforming case. At the same time, the detail of intervention was often hidden. Margaret Archer's distinction between modes of reflexivity (deliberative internal conversations) and collective reflexivity, and her collaboration with Pierpaulo Donati to theorise collective reflexivity, may offer an opportunity to ponder this further. Although a group mind cannot exist, it is possible to have collective reflexivity if group members'

> …relationship has emergent properties and powers that generate 'relational goods' (love, trust, friendship, reciprocity) that cannot be produced by aggregation and are *also* deemed highly worthwhile in themselves. (Archer 2013, p.11)

11.4.4 Studying methods to understand what they can and cannot do in relation to practice change

This research has established practice contexts and jurisdictions as worthy of investigation in relation to practice change. However, the best method(s) to investigate a particular research problem can only be chosen based on a close understanding of what different options are, and what each can and cannot do

to address it. The two most promising (and overlapping) areas for further personal study are ethnographic and case-based comparative methods.

The ethnographic sensibility I brought to interviews, focus groups and transcription, and the ethnodramatic monologues, happened almost by accident as a consequence of my disposition, interests and experience. I would like to develop a more grounded understanding through exploring the practicalities of other methods associated with ethnography in more detail, in particular participant observation, documentary analysis, conversation analysis, and theatre. As suggested with the ethnodramatic monologues, these have potential to deepen analysis and enhance communication of findings.

My engagement with case-based methods was also indirect, coming about through an initial interest in realist evaluation and synthesis. I applied Emmel's idea of realist sampling without at the time actively noticing how this built on and acknowledged previous work of Charles Ragin (2000). I only made a link between his Fuzzy Sets / Qualitative Comparative Analysis and what I was attempting when I read Dixon Woods' essay (2014) on the problem of context in quality improvement and what social science case study methods had to offer. Although my exploratory work was possibly needed first, this inherently mixed method would have added rigour to the configuration of cases, in particular what constituted necessary and sufficient causes.

11.5 Valuing the mundane

With this research, I wanted to understand practice change from a practice perspective, and explain how it had come to be one way rather than another. I hoped to provide a stronger sociological foundation for appreciating speech and language therapy in practice, and what it really takes to change it. At times this has entailed reporting what may appear to be mundane detail in mundane detail. Indeed, I would argue the main contribution of this thesis is greater understanding of how ordinary people in real-world NHS contexts get things done individually and collectively - or don't. It is through understanding mundane detail rather than judging that we can address practice change in a way likely to make a difference.

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Appendices

Appendix 1: Powerpoint presentation

13/08/2017
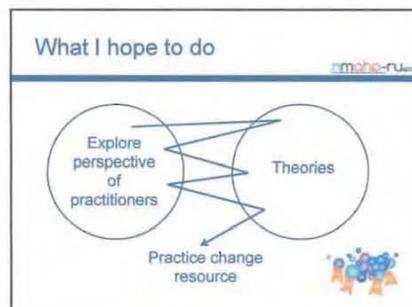
Appendix 2: Ethics approval and response

PH/SG

UNIVERSITY of STIRLING

19 November 2014

Web: http://www.stir.ac.uk/nmhealth/research/ethics/

Professor Pat Hoddinott
Chair
School Research Ethics Committee

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Dear Avril

A qualitative study of practice change in speech and language therapy

SREC 14/15 – Paper No 15 – Version 1

Thank you for submitting your study protocol which was considered by members of the SREC on 12 November 2014.

The committee approved this study which we understand will be submitted to IRAS. This approval is conditional on you making two changes prior to the IRAS submission, which we discussed with you at the meeting:

1. Please add age categories to your data collection sheet.

2. In the information leaflet, under the heading "Value of taking part". Please remove the text about Ethics Committee approval and focus on any benefits to the individual (if any)

We would like to commend you on a thoughtful and well written application. Further issues raised by committee members which you may wish to consider prior to your IRAS submission are:

- How the detail in the information leaflet may influence the data collected through framing effects. In particular the sentence beginning "unfortunately…" which we suggest is removed, as it makes assumptions.

- We thought that imposing a limit to 3 cases was unnecessary and made assumptions.

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The University of Stirling is recognised as a Scottish Charity with number SC 011159

- We suggest you discuss the format of your information leaflet, which differs from the conventional IRAS format, with the Chair of the NHS Research Ethics Committee that you intend to submit to. This may prevent delays in approval.

- Consider a limit on the number of email reminders. We would suggest 2 reminders are acceptable. The word "liberal" should apply to the distribution of leaflets and posters only (currently could be misinterpreted as applying to emails too).

- A43 requires a free text response as to why you are keeping data 12m<3 years.

May I remind you of the need to inform SREC prior to making any amendments to this protocol, of any changes to the duration of the project and provide notification of study completion. A site file of *all* documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the SREC page of the School's website. Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

Ref: SREC 14/15 – Paper No 15 – Version 1
Please quote this number on all correspondence

Yours sincerely
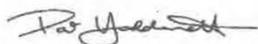
PROF. PAT HODDINOTT
(Chair)
School of Health Sciences Research Ethics Committee

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Professor Pat Hoddinott
Chair, Research Ethics Committee
School of Health Sciences
University of Stirling
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5 January 2015

Dear Pat,

A qualitative study of practice change in speech and language therapy

SREC 14/15 – Paper No 15 – Version 1

Thank you for the very helpful approval letter of 19 November 2014 and discussion at the Research Ethics Committee on 12 November 2014 regarding the above study.

Please find attached the updated pdf of the application I am submitting via IRAS (version 1.1). This incorporates:
   a) The two required amendments
   b) Responses to suggestions made in the letter and during the discussion
   c) A more nuanced understanding of ESRC requirements around data archiving
   d) The study logo

Yours sincerely,

Avril Nicoll.

AVRIL NICOLL
PhD STUDENT

Appendix 3: Research Study Information (Therapists)

UNIVERSITY *of* **STIRLING**

A qualitative research study with community speech and language therapists: 'What does it take to change your practice?'

Please read this leaflet and use page 5 to reply.

Invitation to take part

Are you a speech and language therapist? Do children with speech sound (phonological) difficulties make up a fifth or more of your caseload? If so, I would really appreciate your help with this study. I will need around 1 hour of your time.

My name is Avril Nicoll. I am doing this research as part of a PhD with the Nursing, Midwifery and Allied Health Professions Research Unit. This leaflet explains why I am doing the study, why I need your help, and what taking part would mean for you.

This invitation is going to all community paediatric speech and language therapists in 3 NHS areas and in independent practice in Scotland. I would like to involve up to 50 therapists initially, and hope you will be one of them. However, you do not have to take part. Participation is voluntary, and you can change your mind at any time.

The point of this research

Like all professional groups, speech and language therapists try to change their practice in ways that will benefit clients. Examples of practice change may include:

- Using an intervention, assessment, approach, tool or resource that you haven't used before
- Thinking differently about a client's problem
- Adjusting what you already do to take account of a new idea
- Stopping a particular way of working with clients

This study aims to gather different experiences of practice change.

Greater understanding of these experiences should give the profession and managers a better idea of what it takes to change practice, including how speech and language therapists can be supported to do it.

Experiences of practice change

In taking part, I would like you to tell me about changes you have made in your practice.

The kinds of things I will be asking are:

1. What was the change, and how was it different from what you were already doing?
2. Who or where did the idea for the change come from?
3. How did you manage to put it into practice, and how long did it take? Who or what helped you?
4. Why did you stick with it?
5. Who else knows about this change, and how do they know?
6. Why does this change stand out in your mind?

There are no right or wrong answers. It doesn't matter if you are unsure about any of the answers, if you think your changes aren't very exciting, or even if you find it hard to think of changes.

I am looking for a variety of experiences, so the changes you choose are up to you. It would be good if they relate to children with speech sound (phonological) difficulties. However, if you feel you have better examples of practice change from your work with other client groups, that's fine too. The practice changes can be recent or in the past, whatever stands out in your mind.

We will agree a maximum time for our discussion, usually an hour. The number of changes discussed will vary from person to person.

Logistics of being involved

- Where you talk to me is up to you. I can come to your workplace, or meet you in your home or at a café.
- When you talk to me is up to you. If you prefer, it can be outwith office hours.
- How you talk me is up to you. If we have a one-to-one discussion, this can be in person, over the phone or via Skype or an online message exchange.
- Alternatively you may prefer to talk to me with colleagues. If so, you can take part as a pair or as a focus group.

Please note that the research interviews and focus groups will be audio recorded. The transcript of the audio recording will be anonymised.

Overall, it is important that your individual contribution is as confidential as you wish it to be. If you prefer to keep your involvement completely private from colleagues, I will help you to do that.

If I can do anything else to make it easier for you to take part, please let me know.

Keeping your information safe

Within a small profession there are clearly limits to the level of confidentiality for and within departments that will be possible. While I will take the following basic steps, I will work out finer details as necessary in collaboration with participants.

- I will not tell anyone you have taken part unless disclosure is essential to protect a participant from risk of death or serious harm. The Data Protection Act (1988) applies to your personal details.
- All data will be kept in password protected files on University of Stirling computers or in locked drawers. Audio recordings will be destroyed at the end of the study. The anonymised transcripts and study data will be donated to a secure archive where other researchers will, with appropriate permission, be able to make more use of them in future.
- For this research to be useful, it is important that the findings are shared as widely as possible. This will be done in a number of ways, such as through articles and presentations. Direct quotes may be used, but I will take every care to protect identities of individual participants and departments.

Ethical and professional review

The study has had a favourable ethical opinion from the University of Stirling School of Health Sciences Research Ethics Committee. It has also received Research and Development approval from each NHS Board whose staff are involved, and from the respective managers. The Association of Speech & Language Therapists in Independent Practice is happy for its members to be approached.

The value of taking part

Research plays a part in making the quality of services as high as possible. To be meaningful and of future benefit, this study needs the support of volunteers like you who have the right clinical experience. You may also find that taking part is interesting and enjoyable, and that it would be an appropriate activity to include in your continuing professional development record.

If there is a problem

I hope that taking part will be a positive experience for you, and that the study will generate lots of ideas which will be useful to the profession in future. If however things do not work out as planned:
- The University of Stirling holds insurance policies which apply to this study.
- If you wish to complain, or have any concerns about any aspect of the way you have been treated during the course of this study, you should inform Professor Jayne Donaldson, School of Health Sciences, University of Stirling, Stirling FK9 4LA, tel. 01786 466354, email jayne.donaldson@stir.ac.uk.

What happens now

Express your initial interest and provide your contact details (see p.5). This will let me communicate directly with you and keep you updated on where the study is at.

⬇

Complete a brief information form (e.g. where qualified, number of years working), and give written consent.

⬇

Take part in an interview (one-to-one or paired discussion) or focus group with me. These will be arranged gradually over the course of about a year.

⬇

If you wish, help the wider profession make sense of the findings of this study, and explore how they could be used to support practice change in future.

About the researcher

My name is Avril Nicoll, and I have been a speech and language therapist since 1988. In addition to clinical work, I published and edited *Speech & Language Therapy in Practice* magazine for 14 years. I have also been a user representative in maternity services and worked as a research assistant on two implementation studies in nursing and youth work. This research therefore builds on a long-standing interest in how practice changes.

Please get in touch if you would like to discuss anything about this study.

Email: avril.nicoll@stir.ac.uk

Text: 07511 758350

Phone: 01786 466113

Address: NMAHP Research Unit

           Unit 13, Scion House

           Stirling University Innovation Park

           Stirling FK9 4NF

Please now complete and return the form on page 5. Thank you!

Therapist Reply Form

UNIVERSITY *of* STIRLING

A qualitative research study with community speech and language therapists: 'What does it take to change your practice?'

Please put your initials in the boxes if you agree that:

1. I have read and understood the Research Study Information - Therapists (version 1.2, dated 29.01.2015).

2. I understand that I can choose to take part or not to take part. I can also pull out at any time and do not have to give a reason. Whatever I choose, my rights at work will not be affected.

3. The researcher can contact me using the details below to discuss my participation.

Name of Therapist   Date   Signature

Email

Text / phone number(s)

Address

Return in FREEPOST envelope, or to Avril Nicoll, ESRC PhD Student, email avril.nicoll@stir.ac.uk, NMAHP Research Unit, Unit 13, Scion House, Stirling University Innovation Park, Stirling FK9 4NF

Appendix 4: Focus Group Request

Focus Group Request

UNIVERSITY *of* **STIRLING**

A qualitative research study with community speech and language therapists: 'What does it take to change your practice?'

Please complete and return this form if you have:

a) read the Research Study Information
b) sent your individual contact details to the researcher
c) agreed you would like to take part in this study in pairs or groups.

One person in each planned pair or group should take responsibility for printing the names below. Please then sign and return the form.

Names of participants for a paired interview or focus group:

Person completing form   Date   Signature

Return to: Avril Nicoll, NMAHP Research Unit, Unit 13, Scion House, Stirling University Innovation Park, Stirling FK9 4NF, email avril.nicoll@stir.ac.uk

Focus Group Request v1.1 (11.12.2014)

Appendix 5: Consent Form (Therapists)

Research Consent Form - Therapists

UNIVERSITY *of* **STIRLING**

A qualitative research study with community speech and language therapists:
'What does it take to change your practice?'

Please initial the boxes if you are happy to take part in the study:

1. I have read and understand the Research Study Information - Therapists (version 1.2, dated 29.01.2015).

2. I understand that taking part is voluntary. I can pull out at any time and do not have to give a reason. Whether or not I take part will make no difference to my rights at work.

3. I understand that the researcher will not tell anyone that I have taken part. They will take my name and any details that could identify me out of transcripts and any study reports, articles or presentations.

4. I understand that my interview / focus group will be audio-recorded.

5. I understand that anonymous direct quotations from my interview / focus group may be used in study publications and presentations.

6. I understand that at the end of the study anonymised transcripts will be donated to a secure archive for future use by researchers.

7. I understand that all information about me will be stored securely. It is covered by the Data Protection Act (1998).

8. I agree to take part in this research study.

Name of Therapist Participant   Date   Signature

Name of Researcher   Date   Signature

When complete, 1 copy for participant, 1 for research file.

> *Return to: Avril Nicoll, NMAHP Research Unit, Unit 13, Scion House, Stirling University Innovation Park, Stirling FK9 4NF, email avril.nicoll@stir.ac.uk*

Research Consent Form – Therapists v1.2 (29.01.2015)

Appendix 6: Questionnaire

Participant Details (No._____)

UNIVERSITY *of* STIRLING

A qualitative research study with community speech and language therapists: 'What does it take to change your practice?'

Many thanks for your interest in this research.

For this study, it is important that I talk to speech and language therapists who work in a range of contexts and have a variety of experience. I would therefore be most grateful if you could complete and return this form. It will help me plan who I talk to and when over the next year.

If there is anything you would rather not answer, please just leave it blank. Also, don't worry about being exact, as brief, general answers are all I need.

To make it more confidential, I have not asked for your name on this sheet. Instead, there is a number at the top that I can link to the contact details you have given me.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

1. What is your current job band (if applicable)?

2. Are you full-time or part-time? (If part-time, what %?)

3. Where is your main base?

4. What geographical area do you cover?

5. Roughly what % of your caseload is children with speech sound difficulties?

6. Can you briefly describe the rest of your caseload?

7. What external training, if any, have you been on in the last few years that relates to children with speech sound difficulties?

8. How often do you take speech and language therapy students on placement?

9. Where did you study speech and language therapy?

10. What year did you qualify?

11. What degree were you awarded?

12. What other qualifications, if any, do you have?

13. What other careers, if any, have you had?

14. How many periods away from your job lasting at least 6 months have you had in the past few years?

15. Are you male or female?

16. Please circle your age band

   21-29   30-39   40-49   50-59   60+

17. And finally...

Roughly how easy do you think it will be for you to think of practice changes? (Put a cross at a point on the scale that feels right)

Very easy		Very hard

Participant Details v1.1 (11.12.2014)

Appendix 7: Topic guide

Topic Guide

UNIVERSITY *of* STIRLING

A qualitative research study with community speech and language therapists:
'What does it take to change your practice?'

Topics	Exemplar questions
• Priorities	i. What practice changes would you like to tell me about? ii. What was your role (job) at the time of each? iii. Which is most important to you? / Which would you like to start with?
• Social context • Ideas about practice • Ideas about agency (individual / collective) • Time	i. What were you already doing (to deal with this kind of problem)? ii. Who (or where) did the idea for the change come from? iii. How was it different from what you were already doing? / What did you have to do differently? iv. What happened to this idea? What did you do with it? How did you feel about it? What were other people (who?) saying? How did that affect your thinking? v. What would be happening now if this idea had never reached you?
• Reasons for action (individual / collective) • Ideas about practice, processes, resources	i. Why did you act on this idea (at this time)? ii. What did you have to do to put it into practice? / How did you manage to get it to happen? How did you feel about it at the time? iii. Who (or what) helped you, and how? iv. What reactions did you get (and from whom)? How did that affect your thinking?

Topic Guide v1.1 (11.12.14)

• Ideas about power • Time	v. vi. vii.	What 'things' had to change too (assessments, materials) and what / who did that involve? How long did this take? What adaptations did you make? Why? How?
• Reasons for action (individual / collective) • Ideas about practice, roles • Social context	i. ii. iii. iv. v. vi.	Why did you stick with it (the change)? How did you know it was going to stick? If you had been in a different role at the time, could it still have happened? Why / why not? Could you have gone further (with the change)? Would you go back now? What other consequences, if any, has this change had for your practice? For your clients? Who else knows about this change? How do they know? When did they know? Why does this change stand out in your mind?

Note: The topic areas are drawn from the conceptual framework for this study, which is based on de Souza's (2013) interpretation of Margaret Archer's Morphogenetic Approach (1995).

References

Archer, M.S. (1995) *Realist social theory: the morphogenetic approach*. Cambridge: Cambridge University Press.

de Souza, D.E. (2013) Elaborating the Context-Mechanism-Outcome configuration (CMOc) in realist evaluation: A critical realist perspective. *Evaluation,* 19 (2), pp. 141-154.

Appendix 8: Glossary of findings

Approach
- An element of Intervention which can change
- Theoretical layer / Intellectual work
- The underlying theory of an intervention's power to effect change in a child's speech

Candidacy
- One of four aspects of the practice context that helps explain different trajectories of practice change
- An application of a construct about the negotiated work of accessing healthcare generated by Dixon Woods et al. (2006) which encompasses complex, ongoing, situated judgements about who should start, continue with, and end specialist speech and language therapy
- Comprises two dimensions each with three underpinning concepts (specialist SSD knowledge: impairment, intelligibility, interventions; and therapeutic sensibility: personal impact, motivation, risk) which are open to change in depth of application

Caseload
- One of four aspects of the practice context that helps explain different trajectories of practice change
- Comprises four dimensions (size, composition, time, distribution)

Cases
- Complex configurations of the trajectory of change of everyday integrated speech and language therapy work
- Six cases identified by the theory of SSD practice change are Transforming, Redistributing, Venturing, Delegating, Personalising and Refining

Composition
- A dimension of Caseload relevant to SSD practice change
- Caseload composition varies in scope, SSD severity ratio, unpredictability, and therapist equity

Delegating case
- A case (trajectory) of practice change

- Specialist SSD intervention via a therapy partner becoming part of local routine practice

Distribution	• A dimension of Caseload relevant to SSD practice change • Distribution of Caseload work varies by who takes responsibility (therapist, manager, hub, service)
Dosage	• An element of Intervention which can change • Logistical layer / Organisational work • How much, how often, how repetitively, how regularly, how distributed, or for how long an intervention is offered
Expectations	• A dimension of Service relevant to SSD practice change • Dominant narratives include Share, Negotiate or Design
Focus	• An element of Intervention which can change • Theoretical layer / Intellectual work • What a child is asked to do in therapy tasks so the selected Approach and Target(s) can work their effect
Format	• An element of Intervention which can change • Logistical layer / Organisational work • Who is involved in intervention and how
Impairment	• An underpinning concept of the specialist SSD knowledge dimension of Candidacy • Relates to knowledge of how severe, entrenched, persistent, disordered and consistent a child's SSD is
Instrumental interventions	• High-tech visual biofeedback tools such as EPG (electropalatography)
Intelligibility	• An underpinning concept of the specialist SSD knowledge dimension of Candidacy • Relates to knowledge of how intelligible the child is to the therapist, to different people and in different contexts

Intervention	• One of four aspects of the practice context that helps explain different trajectories of practice change
	• Comprises 4 layers (theoretical, logistical, processual, observable) and 10 elements (Approach, Target, Focus, Meta-language; Place, Format, Dosage; Scaffold, Session; Material) which are open to change
Interventions	• An underpinning concept of the specialist SSD knowledge dimension of Candidacy
	• Relates to knowledge of which intervention approaches would most help the child at this time, and how to provide them
Investment in SSD	• A dimension of Service relevant to SSD practice change
	• Varies by choices of whether and how to invest in SSD at the specialist level, and over what period of time
Logistical layer	• A layer of Intervention which can change
	• Recognises it has to be provided somewhere, by someone in a quantity, with these Place, Format and Dosage options locally determined as conventional or unconventional
Material	• An element of Intervention which can change
	• Observable layer / Creative work
	• The things those involved do or use to make participating in intervention interesting and fun
Mechanism	• An underlying layer of social ontology
	• Agential, cultural and structural mechanisms come together to generate events which give rise to experiences
Meta-language	• An element of Intervention which can change
	• Theoretical layer / Intellectual work
	• A shared way of thinking and talking about speech sounds and intervention

Motivation	• An underpinning judgement of the therapeutic sensibility dimension of Candidacy
	• Relates to judgements about how willing the child, parent and nursery / school are to support therapy and the availability of a therapy partner
Named interventions	• Whole intervention packages with a specific name and literature (e.g. Multiple Oppositions, Stimulability, Core Vocabulary, Cycles, Colour Coding, Metaphon)
Non-mainstream interventions	• Named interventions which do not have mainstream academic support in relation to SSD but may be used in practice
Non-traditional interventions	• A heterogenous group of intervention approaches from the SSD literature which did not form part of traditional practice (Multiple Oppositions, Stimulability, Complexity, Core Vocabulary, Cycles, Perception)
Observable layer	• A layer of Intervention that can change
	• The Material element and creative work that can be observed in a Session
Organisational model	• A dimension of Service relevant to SSD practice change
	• Varies by structure, e.g. geographical hub or hierarchical model, history and recruitment challenges
Personal impact	• An underpinning judgement of the therapeutic sensibility dimension of Candidacy
	• Relates to judgements about how much the SSD affects a child's wellbeing, bothers the parent, and is a relative priority for the family at this point
Personalising case	• A case (trajectory) of practice change
	• Highly personalised intervention becoming part of local routine practice with children with SSD

Place	• An element of Intervention which can change
	• Logistical layer / Organisational work
	• Where a child is seen for intervention
Possibilities	• A dimension of Service relevant to SSD practice change
	• Practice varies in what is routinely possible or not possible (e.g. groups, pathways, intensive intervention)
Practice	• The mundane and interconnected things people do individually and collectively to support people to live well and build a world worth living in (see e.g. Kemmis 2012)
Practice change	• The mundane and interconnected things people do differently over time individually and collectively to support people to live well and build a world worth living in (see e.g. Kemmis 2012)
Practice context	• Four aspects of practice which are modifiable by speech and language therapists (Intervention, Candidacy, Caseload, Service) and thus contribute to different trajectories of practice change
Processual layer	• A layer of Intervention that can change
	• Harnessing Scaffold and Session elements to supporting a child through intervention so they can change their (speech) behaviour
Redistributing case	• A case (trajectory) of practice change
	• Negotiated periods of intensive intervention for selected children with SSD becoming part of local routine practice
Refining case	• A case (trajectory) of practice change
	• Individual or informal groups of therapists making ongoing adjustments to intervention for children with SSD
Risk	• An underpinning judgement of the therapeutic sensibility dimension of Candidacy

- Relates to judgements about what is already being done to support the child, how they are already improving, who is best placed to support them and what will happen without intervention

Scaffold
- An element of Intervention which can change
- Processual layer / Scaffolding work
- How behavioural techniques are used to support progress

Service
- One of four aspects of the practice context that helps explain different trajectories of practice change
- Comprises four key dimensions (organisational model, investment in the SSD jurisdiction, expectations, and what was routinely possible)

Session
- An element of Intervention which can change
- Processual layer / Scaffolding work
- How elements of intervention are ordered and structured to meet the needs of a child in an allotted timeframe

Size
- A dimension of Caseload relevant to SSD practice change
- Caseload size varies by absolute numbers, interpretation of numbers, and response

Specialist SSD knowledge
- One of two dimensions of Candidacy
- Depth of application helps explain different trajectories of practice change
- Underpinning knowledge is around impairment, intelligibility, and suitable interventions

Target
- An element of Intervention which can change
- Theoretical layer / Intellectual work
- The specific speech sound(s) and / or other linguistic units a child is exposed to within the selected Approach

Theoretical layer
- A layer of Intervention that can change

- Distinguished by its attention to the specific power of an intervention to make a difference to a child's SSD involving a combination of the changeable elements Approach, Target, Focus and Meta-Language

Theory of SSD practice change

- Best explanation from this research of how and why, from a practice perspective, specialist speech and language therapy for children with SSD came to be one way rather than another
- Comprises six configured cases of practice change emerging through patterns of work in four interdependent aspects of the practice context (Intervention, Candidacy, Caseload, Service)

Therapeutic sensibility

- One of two dimensions of Candidacy
- Depth of application helps explain different trajectories of practice change
- Underpinning judgements are around personal impact, motivation and risk

Time

- A dimension of Caseload relevant to SSD practice change
- Time on Caseload varies by culture and its meaning as an outcome measure

Traditional interventions

- A heterogenous group of intervention approaches from the SSD literature which combined as traditional practice (Sound-by-Sound, Minimal Pairs, Colour Coding, Metaphon, Phonological Awareness, Psycholinguistic approach)

Trajectory

- See Cases

Transforming case

- A case (trajectory) of practice change
- Non-traditional SSD interventions for selected children becoming part of local routine practice

Venturing case

- A case (trajectory) of practice change

- Individual or informal groups of therapists trying out or using interventions that are not part of local routine practice with selected children with SSD

Appendix 9: Signposting resources mentioned by participants

Black Sheep Press — https://www.blacksheeppress.co.uk/

Bowen, Caroline — https://speech-language-therapy.com/index.php?option=com_content&view=featured&Itemid=101

Broomfield, Jan — https://www.helpwithtalking.com/Member/Dr-Jan-Broomfield

Care Aims (Consultancy from Kate Malcomess) — http://careaims.com/

CLEAR Phonology Screening Assessment — http://www.clear-resources.co.uk/ClearReviewsPage1.html

Colour Coding (Sunnybank) — Resources in informal circulation, with no original ones online, but see http://www.inverlochyprimary.co.uk/wp-content/uploads/2015/11/Colour-Coding-Introduction-Instructions-for-parents.pdf

Core Vocabulary — https://clinical-research.centre.uq.edu.au/profile/473/barbara-dodd

Cued Articulation — http://www.soundsforliteracy.co.uk/cued-articulation.html

Cycles — https://www.researchgate.net/profile/Barbara_Hodson2

DEAP (Diagnostic Evaluation of Articulation and Phonology) — http://www.pearsonclinical.co.uk/AlliedHealth/PaediatricAssessments/PhonologyandArticulation/DiagnosticEvaluationofArticulationandPhonology(DEAP)/

Early Years Collaborative — https://www.webarchive.org.uk/wayback/archive/20160401140103/http://www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative

Empty Set (and other minimal / maximal pair contrasts)	See Gierut, Judith https://www.researchgate.net/publication/21707636_The_Conditions_and_Course_of_Clinically_Induced_Phonological_Change
EPG	http://www.rose-medical.com/electropalatography.html
Gierut, Judith	https://www.ncbi.nlm.nih.gov/pubmed/?term=judith+gierut
Intelligibility in Context Scale	http://www.csu.edu.au/research/multilingual-speech/ics
Knowledge Network	http://www.knowledge.scot.nhs.uk/home.aspx
Locke Test	https://speech-language-therapy.com/index.php?option=com_content&view=article&id=46:speechax&catid=9:resources
Maximal Oppositions	See Gierut, Judith See Empty Set
Metaphon	Howell, J. and Dean, E. (1994) *Treating phonological disorders in children: Metaphon – theory to practice.* 2nd edn. London: Whurr.
Multiple Oppositions	https://www.researchgate.net/profile/Lynn_Williams5 https://www.scipapp.com/
Nuffield Dyspraxia Programme	https://www.ndp3.org/
Perception	See Rvachew, Susan See Locke Test

Quick Screener (Bowen)	https://speech-language-therapy.com/index.php?option=com_content&view=article&id=46:speechax&catid=9:resources
Rvachew, Susan	https://developmentalphonologicaldisorders.wordpress.com/
	https://www.ncbi.nlm.nih.gov/pubmed/?term=susan+rvachew
	Rvachew, S. and Brosseau-lapre, F. (2016) *Developmental phonological disorders: foundations of clinical practice.* 2nd edn. San Diego: Plural Publishing.
SAILS (Speech Assessment and Interactive Learning System)	https://itunes.apple.com/ca/app/sails/id1207583276?mt=8
SHANARRI Wellbeing Wheel (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included)	http://www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing
SPAA-C (Speech Participation and Activity Assessment of Children)	http://www.csu.edu.au/research/multilingual-speech/spaa-c
Stackhouse and Wells	Stackhouse, J. and Wells, B. (1997) *Children's speech and literacy difficulties: a psycholinguistic framework.* London: Whurr.
STAP (South Tyneside Assessment of Phonology)	http://www.stass.co.uk/publications/stap

Stimulability	https://speech-language-therapy.com/index.php?option=com_content&view=article&id=46:speechax&catid=9:resources
	Miccio, A. and Elbert, M. (1996) Enhancing stimulability: a treatment program. *Journal of Communication Disorders,* 29 (4), pp. 335-351.
Talking Mats	https://www.talkingmats.com/
Textbooks	Bowen, C. (2014) *Children's speech sound disorders*. 2nd edn. Chichester: Wiley-Blackwell.
	Williams, A.L., McLeod, S. and McCauley, R.J. (2011) *Interventions for speech sound disorders in children.* Baltimore: Paul H. Brookes.
TOMS (Therapy Outcome Measures)	Enderby, P. and John, A. (2015) *Therapy outcome measures for rehabilitation professionals*. 3rd edn. Guildford: J&R Press.
Triage	Superseded by request-for-assistance: http://www.gov.scot/Publications/2017/06/1250/5
What Works database	https://www.thecommunicationtrust.org.uk/whatworks
Working with Phonology book	Lancaster, G. and Pope, L. (1989) *Working with children's phonology.* Bicester: Speechmark.