

**Children as Partners in Speech and Language
Therapy:
A Systematic Review and Qualitative Study of Service
Delivery and Home Practice**

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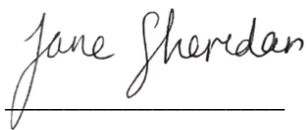
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Summary

Speech, language, and communication needs (SLCN) affect up to 10% of children and can impact educational, social, and emotional outcomes (McLeod & McKinnon, 2007; Norbury et al., 2016). Access to speech and language therapy from childhood has the potential to improve these long-term outcome trajectories, highlighting the importance of service access from an early age (Broomfield & Dodd, 2011; Dubois et al., 2020; Liu et al., 2025; RCSLT, 2024a). Speech and language therapy aims to support children with SLCN to achieve their goals, through evidence-based, family-centred approaches, informed by evolving models of disability and neuro-affirming practice (ASHA, 2005; Dunst, 2002; Gaddy & Crow, 2023). Home practice is viewed as an integral and core component of speech and language therapy (Doherty et al., 2025), yet little research has explored children's views on this regular feature of therapy. Children have a right to express their views on matters that concern them, and have these views listened to (United Nations, 1989). Therefore, the present study aimed to explore children's views of home practice and how it might be designed to best meet their needs. To explore this aim, this study used a multi-phased qualitative design, with two separate components.

Firstly, a systematic review synthesised current literature on children's views of service delivery to explore the broader therapy context in which children experience home practice. A qualitative synthesis approach was employed, including a comprehensive search of four databases, two stages of screening, data extraction, and analysis using narrative synthesis (Grant & Booth, 2009; Popay et al., 2006). This review synthesised 14 studies, which suggest that children have limited agency in how speech and language therapy is utilised to promote their development. The results are discussed under four main themes, summarising children's expectations and motivation for therapy, their views on service delivery and intensity, the key elements they value within intervention, and the influence of relationships on their therapy experiences. Children's views on home practice were reported in only three studies, where they appeared as a minor subsection rather than a central focus of the findings.

The second component was a qualitative interview study exploring children's views of home practice in greater depth (Bradbury-Jones et al., 2017). Semi-structured interviews were conducted with five children aged 7–12 using accessible, multi-method techniques inspired by the Mosaic approach (Clark, 2017). Thematic analysis (Braun & Clarke, 2021) identified four main themes summarising children's experiences of therapy sessions, their descriptions of home practice, barriers and facilitators to feeling motivated, and their ideas for improving home practice. Findings highlighted wide variation in experiences, with engagement influenced by understanding of goals, enjoyment, difficulty, and whether work was individualised to them. Children reported greater motivation when activities were tailored, enjoyable, and supported by parents and therapists, and they suggested increased choice, variety, and use of games or online tools to improve home practice.

Considering the findings collectively, several key points emerge. Firstly, home practice is currently understood as both a useful way to help children generalise skills learnt in therapy and as a method to increase practice dosage in under-resourced services. However, speech and language therapists' attempts to provide extra work and resources often do not meet families' needs, reducing engagement and causing frustration or overwhelm. Children are frequently excluded from initial discussions about their expectations and goals, potentially limiting their understanding of the value of therapy and affecting their readiness to engage in home practice. Additionally, the findings suggest that improving children's motivation to participate in therapy and home practice requires greater emphasis on supporting autonomy, fostering early experiences of success, incorporating fun and play, and harnessing the influence of supportive relationships with parents, professionals, and peers. Systemic shifts are required to enable clinicians to provide more child-centred home practice, and the potential advantages of adopting a coaching model are therefore considered. Overall, this study emphasises the need to reconceptualise home practice as a long-term investment in building families' confidence and capacity for self-management, and demonstrates the value of incorporating children's views into research and service design.

(for a child-friendly summary, see Appendix 15 or the following link: <https://youtu.be/FJnoilO14uo>)

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Abbreviations

AAC: Augmentative and Alternative Communication

ADHD: Attention Deficit Hyperactivity Disorder

ASD: Autism Spectrum Disorder

ASHA: American Speech-Language-Hearing Association

CASP: Critical Appraisal Skills Programme

CCAT: Crowe Critical Appraisal Tool

CIS: Child Interview Study

COREQ: Consolidated Criteria for Reporting Qualitative Research

DLD: Developmental Language Disorder

EBP: Evidence-Based Practice

IASLT: Irish Association of Speech and Language Therapists

ICF: International Classification of Functioning, Disability and Health

JB: Joanna Briggs Institute

PPI: Public and Patient Involvement

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

RCSLT: Royal College of Speech and Language Therapists

SDT: Self-Determination Theory

SLT: Speech and Language Therapist

SLCN: Speech, Language, and Communication Needs

SR: Systematic Review

SSD: Speech Sound Disorder

Section One:
Introductory Literature Review

Chapter 1: Setting the Scene

1.1 Introduction to Speech and Language Therapy

1.1.1 *Speech, Language, and Communication Needs*

Communication is a central part of human interaction, essential for learning, connecting with others, and navigating daily life. According to the United Nations, every person has the right to accessible communication and should be facilitated in using communication methods of their choice (United Nations, 2006), recognising that some individuals require additional supports to communicate with others. The term “speech, language, and communication needs” (SLCN) is used in different ways in the literature. Some authors use it to refer to all communication difficulties, regardless of cause or co-occurring conditions (e.g., ICAN/RCSLT, 2018), while others limit it to difficulties that are not linked to another disorder (Lindsay, 2011). This study uses the term SLCN to describe any communication difficulty that occurs either in isolation or secondary to another developmental or acquired condition. Examples of SLCN include articulation disorders, language comprehension or expression difficulties, social communication differences, fluency difficulties, among many other communication profiles (Lindsay, 2011).

While reported prevalence rates vary across studies, research suggests up to 10% of children experience SLCN (McLeod & McKinnon, 2007; Norbury et al., 2016). Even higher rates are reported in areas of socioeconomic disadvantage, where up to 50% of children may experience SLCN (ICAN/RCSLT, 2018). This social gradient is evident from early childhood and has been attributed to the influence of environmental, material, and psychosocial factors on language development (Reilly & McKean, 2023), although some scholars argue that observed disparities are also shaped by raciolinguistic ideologies embedded within language assessment and educational systems (e.g., Cushing, 2023), a perspective that is beyond the scope of the present study. As communication underpins many aspects of everyday life, SLCN have been associated with poorer educational, behavioural, and mental health outcomes (Langbecker, 2020; RCSLT, 2024b). Children with SLCN are more likely to experience literacy difficulties and receive lower academic grades than their

peers (Hayiou-Thomas et al., 2017; Whitehouse et al., 2009). Communication breakdowns with family members and friends can make it harder to form and maintain relationships, with potential impacts on emotional wellbeing (Conti-Ramsden & Botting, 2004). These challenges can also be associated with behavioural difficulties and antisocial behaviour, with 60% of children in the youth justice service having recognised communication needs (Bryan et al., 2007). Over time, language inequalities linked to socioeconomic disadvantage are likely to persist and potentially widen across the lifespan without providing adequate support from childhood (Reilly & McKean, 2023; Taylor et al., 2013;2022), and can even affect employability and broader life opportunities as adults (Cronin et al., 2020).

These difficulties highlight the importance of ensuring that children receive appropriate support as early as possible. Speech and language therapy has been shown to improve both communication and participation outcomes for children (Broomfield & Dodd, 2011; Law et al., 2005; Liu et al., 2025; RCSLT, 2024a), and timely, effective support has the potential to influence longer-term educational, social, and employment trajectories (Dubois et al., 2020).

1.1.2 The Role of Speech and Language Therapy

Speech and language therapy is a health service provided across the lifespan, from neonatal to palliative care services (Joffe et al., 2008). Speech and language therapists (SLTs) assess, diagnose, and support people with a wide range of communication and swallowing difficulties. Their work may involve helping individuals to develop or regain skills in speech, language, voice, fluency, social communication, and safe eating and drinking, depending on their needs (Charalambous et al., 2025; Pring et al., 2012; Roulstone et al., 2012a). SLTs work in a variety of settings, including hospitals, schools, community settings, and homes, and often collaborate with families, educators, and other professionals to support meaningful participation in everyday life (IASLT, 2023). This thesis focuses on a core area of practice for many SLTs: supporting children with SLCN.

Many SLTs (e.g., approximately 60% in the UK) work with children and adolescents in primary care, disability, and education settings (RCSLT, n.d.). In this area of practice, SLTs use a range of approaches to support children and families with communication skills that enable participation in learning, play, social interaction, and other activities (Reed, 2017; Roulstone & Wren, 2012). This work may involve working with the child on specific speech or language goals, adapting environments to be more accessible, and collaborating with parents, teachers, and other communication partners (Morgan et al., 2019). Intervention aims to be tailored to the child's individual needs and contexts, with the goal of supporting meaningful communication (Biggs et al., 2018; Morgan et al., 2019; Reed, 2017).

1.1.3 Evidence-Based Practice

SLTs, alongside all healthcare professionals, aim to use evidence-based practice (EBP) to ensure they offer the most effective support for children with SLCN (Greenwell & Walsh, 2021; Reilly, 2004). While EBP can be interpreted in different ways (Dodd, 2008), many SLTs are familiar with the definition provided by the American Speech-Language-Hearing Association (ASHA): “an approach in which current, high-quality *research evidence* is integrated with *practitioner expertise* and *client preferences and values* into the process of making clinical decisions” (ASHA, 2005). These three pillars are summarised briefly below, and will be referred to across the chapter.

Research evidence: Dodd (2008, p.59) states that research evidence is built by asking a specific research question: “which intervention approach (that specifies content, amount, and service delivery) works best with a well-specified diagnostic group?”. While it is beyond the scope of this paper to specify the content and efficacy of the countless specific intervention approaches that exist for children with SLCN, important evidence-based considerations in terms of service delivery and dosage will be discussed.

Clinician expertise: SLTs often use reflection of their own experience along with discussions with colleagues and seniors to make clinical decisions (McCurtin &

Clifford, 2015). Continuous professional development, workshops, and training also increases clinician knowledge and engagement in EBP (Greenwell & Walsh, 2021). However, factors influencing intervention effectiveness extend beyond clinician knowledge and include rapport, attitudes, and personal characteristics (Ebert & Kohnert, 2010), which are discussed later.

Client preferences and values: Clinicians have a responsibility to understand client needs and respect their choices. The influence of family-centred practice (Dunst, 2002), neuro-affirming practice (Dwyer, 2022), and therapeutic alliance (Connery et al., 2022) on SLT's approach to hearing families' perspectives will be discussed later in this chapter.

Although the overall aim of speech and language therapy is to support children in achieving meaningful communication goals using EBP, service organisation, how intervention is delivered, and intervention intensity may vary considerably.

1.2 Service Delivery Considerations

1.2.1 Tiered Approaches

Just as children with SLCN have diverse profiles, the speech and language therapy service offered can differ depending on the child's needs and national/local healthcare organisation. 'Service delivery' is the term used to describe how intervention is accessed, organised, and implemented, including the setting, structure, format, dosage, and methods and degree of child and family involvement in intervention (Ruggero et al., 2012). Service delivery can be organised into three "tiers" of speech and language prevention and intervention (Ebbels et al., 2019; Law et al., 2013):

- 1) preventative, universal approaches for the whole population,
- 2) targeted support for families of children who are at risk of SLCN, and
- 3) specialist and individualised intervention for children with SLCN

The SLT's role in the universal and targeted tiers of intervention primarily involves raising public awareness of communication difficulties, impacts, and supports (Ebbels et al., 2019), collaborating with teachers to implement language and vocabulary instruction for the whole class (Dobinson & Dockrell, 2021), and providing educational-based groups for family or other professionals. Therefore the specialist tier is where the SLT has more individualised and direct contact with the child and family. There are four main processes within the specialised tier, which include comprehensive assessment, collaborative goal setting, individualised intervention, and evaluation and outcome measurement (ASHA, 2016; Malcomess, 2005).

Ebbels et al. (2019) expand upon this tiered model and break down specialist intervention into two separate groups: indirect and direct individualised intervention. Indirect intervention involves working with communication partners such as parents or school staff, to effect change in the communication environment (Ebbels et al., 2019). Commonly used indirect interventions include parent-child interaction therapy for young children with delayed language development (e.g., Roberts & Kaiser, 2011; Spencer, 2013), or communication partner interventions to support children using AAC devices (IASLT, 2017; Kent-Walsh, 2015). Conversely, direct intervention involves the SLT working directly with the person who has the communication need to address their specific goals. This approach is commonly used with school aged children with developmental language disorder (DLD), speech sound disorders (SSD), or those learning to communicate with a new augmentative alternative communication (AAC) device, and might involve teaching and practising explicit communication skills, discussing the impact communication difficulties, or learning strategies the child can use independently at home or in school (Dodd, 2014; Light & McNaughton, 2014; Tarvainen et al., 202).

While indirect and direct approaches differ in who delivers the intervention, direct intervention itself can be organised and delivered in a variety of ways. This thesis concentrates on direct intervention for children with SLCN, and therefore attention now turns to the range of service delivery considerations relevant to this approach.

1.2.2 Direct Intervention Service Delivery

Direct intervention may take place in different settings including clinics, at home, within a specialist language or support class, school-based individual sessions (IASLT, 2023). Therapy can be delivered individually or in small groups (Boyle et al., 2009), and in person or online (teletherapy) (Scott et al., 2024). From an evidence-based perspective, it is not always clear which service delivery models are most effective. For example, a systematic review found insufficient high-quality studies to draw definite conclusions, although outcomes appeared broadly equivalent across direct versus indirect therapy, individual sessions versus groups, home versus clinic settings, and classroom versus pull-out models for children aged five years and younger (Schooling et al., 2010).

Considering clinician experience and family perspectives is also important when discussing evidence-based service delivery (ASHA, 2005). Research in this area has reported mixed views, displaying the diverse needs and preferences of children and families. For example, in relation to intervention structure, some parents of children with intellectual disability reported that group sessions were beneficial for practising social skills, while others perceived greater benefit from individual therapy (Carroll, 2010). Similarly, many SLTs recognise the potential advantages of group intervention but report practical barriers, such as difficulty filling spaces, limited physical space, and lack of confidence in delivering groups (Liddle et al., 2011). Teletherapy has often been used to address some of these challenges, but views on this approach are also mixed. Reported benefits include the ability for SLTs to observe the child in a familiar environment, reduced travel for families and clinicians, and increased convenience and flexibility (Farren et al., 2022; Passalacqua & Perlmutter, 2022). However, challenges such as reduced child engagement, technical difficulties, preferences for in-person interaction, and limited training indicate that teletherapy may not be suitable for all children or families (Farren et al., 2022; Passalacqua & Perlmutter, 2022).

Other aspects of service delivery such as parent involvement and home practice have been discussed in more detail in chapter 2. While service delivery models describe how intervention is organised and delivered, an equally important

consideration is how much intervention is provided, making dosage a key component of EBP.

1.2.3 Considerations on Intervention Dosage and Intensity

Decisions about intervention intensity, frequency, and duration are central to speech and language therapy, and are commonly described using the concept of intervention dosage.

Warren et al. (2007) suggest five terms that should be used consistently by SLTs and other health professionals when discussing the amount of intervention provided (see table 1.1 for a description of two other cases where each of the terms is described):

1. Dose: the number of teaching episodes carried out in one intervention session. For example, a child receives 50 models/recasts of past tense verbs ending in “-ed” during a 45 minute session.
2. Dose form: defines how those teaching episodes are carried out. In this example, the child leads the session and decides to play with toy animals, so the SLT naturally models and recasts the past tense during the play (e.g., “the cow jumped,” “the dog barked”)
3. Frequency: how often sessions occur. For example, the child attends therapy once per week.
4. Duration: the overall length of time of the intervention block. For example, therapy continues for eight weeks.
5. Cumulative intervention intensity: the product of dose, frequency, and total intervention duration. In this example: 50 teaching episodes x 1 session per week x 8 weeks = 400 teaching episodes in total.

There is only preliminary evidence available on optimal intervention intensity in speech and language therapy. For example, high intensity is more effective with childhood apraxia of speech and phonological disorders (Kaipa & Peterson, 2016), although research is inconclusive for many other children’s speech and language interventions (Zeng et al., 2012).

Research on recommended dose form is also limited, and highly dependent on the child's attention, motivation, and responsiveness to different activity types (Frizelle et al., 2021; Warren et al., 2007). For example, Frizelle et al. (2021) compared implicit dose forms, where language is targeted through naturalistic exposure, with explicit dose forms involving direct teaching. Their findings suggested potential advantages for explicit teaching with additional supports over implicit learning alone for children with DLD. Play-based versus structured learning is another debated topic in dose form. For example, play-based learning has been shown to be effective within early intervention and with children with autism (Gibson et al., 2021; Lindsay et al., 2017; McLeod et al., 2017). However, for older children, games and play are more often used as rewards rather than as the primary dose form. This frames play as an external incentive for completing therapy tasks, an approach that has been criticised for undermining autonomy and intrinsic motivation (Brackenbury & Kopf, 2022).

Other considerations such as the quality of teaching episodes, difficulty defining teaching episodes, and whether doses are massed into longer, infrequent sessions or distributed in short, frequent sessions can all impact the effectiveness of the intervention (Justice, 2018; Warren et al., 2007). Parents, teachers, and other adults can contribute at home or at school to increase dosage or frequency and help generalisation of skills, however it is important that sufficient support and guidance is provided to maintain the teaching episode quality (Baker, 2012).

It is apparent that dosage is a key component of service delivery and EBP. However, the complexity and lack of clear guidance regarding appropriate intensity, dose form, and people implementing the dosage show that careful collaboration and an individualised approach is required to ensure that intervention is effective and tailored for each child. Additionally, decisions about what intervention entails, including dosage, other service delivery aspects, and intervention goals are not only informed by EBP, but are also influenced by broader beliefs about disability, participation, and behaviour change. The following section therefore explores key models which have influenced speech and language therapy practice.

Table 1.1 *Examples to Demonstrate Dosage in Speech and Language Therapy*

	Example 1	Example 2
Case	A 2 year old with delayed language uses approximately 50 single words. The child's parent attends weekly group meetings with other parents where an SLT discusses strategies to support development of 2-word phrases.	A 7 year old child has difficulty articulating the /s/ sound. The child attends direct intervention with an SLT who is following a traditional articulation approach (explain)
Teaching episode definition	Parent completes the technique of modelling 2-word phrases, e.g.: - Using new phrases (parent picks up ball and labels "<i>red ball</i>") - Expanding the child's speech (child: "doggy", parent: "doggy barking")	The child attempts to elicit the /s/ sound at the appropriate level (i.e. starting with the sound in isolation and working up to s+vowel, words, phrases, sentences, reading etc.) with feedback and/or recasting provided by the SLT.
Dose form	Child-led, play-based activities. Parent follows child's lead in play activities, providing two word models related to the child's focus of interest.	Structured, drill based games. i.e., the child receives a piece of a game each time they produce the /s/ sound.
Dose	20 teaching episodes per day	100 teaching episodes in the session
Frequency	Parent focuses on strategy 5 days per week	Direct intervention with child and SLT occurs 1 time per week
Duration	SLT supports parent over a period of 6 weeks	Direct sessions occur over a period of 8 weeks
Cumulative intervention intensity	$20 \times 5 \times 6 =$ 600 teaching episodes	$100 \times 1 \times 8 =$ 800 teaching episodes

1.3 Key Models of Practice

1.3.1 Introduction to Key Models

In order to explore how best to deliver direct interventions with children, we must first explore the models and theories that shape how children's therapy looks today. Speech and language therapy as a discipline has evolved considerably over the past century (Law et al., 2013). Over time, it has drawn on theories from related disciplines while also responding to changing societal understandings of disability and communication (Donaldson et al., 2017). This section outlines key theoretical and clinical models that have shaped the profession over time, including both influential and currently popular models in modern practice, in order to provide context for how speech and language therapy is currently delivered.

1.3.2 Models of Disability

Historically, disability was mostly conceptualised through a medical model perspective, which dominated professional and societal understandings throughout most of the twentieth century (Abrahams et al., 2019; Donaldson et al., 2017). Within this model, disability is understood as a deficit that requires diagnosis and treatment. Speech and language therapy developed within this context, and early practice was largely impairment-focused: assessment centred on identifying deficits, goals were set by professionals, and intervention aimed to "fix" the individual's communication difficulties (Duchan, 2001). For example, traditional approaches to stuttering or articulation disorders often focused on changing the child's speech production through structured drills, rate control strategies, or auditory feedback, with less attention to environmental barriers or participation in everyday communication (Duchan, 2021). The medical model has been criticised for overlooking the social and environmental obstacles faced by people with disabilities, and for positioning disability primarily as the individual's responsibility to solve (Llewellyn & Hogan, 2000).

In contrast, the social model of disability, first brought about during disability rights movements in the 1970s and 1980s (Oliver, 1983;2013), proposes that

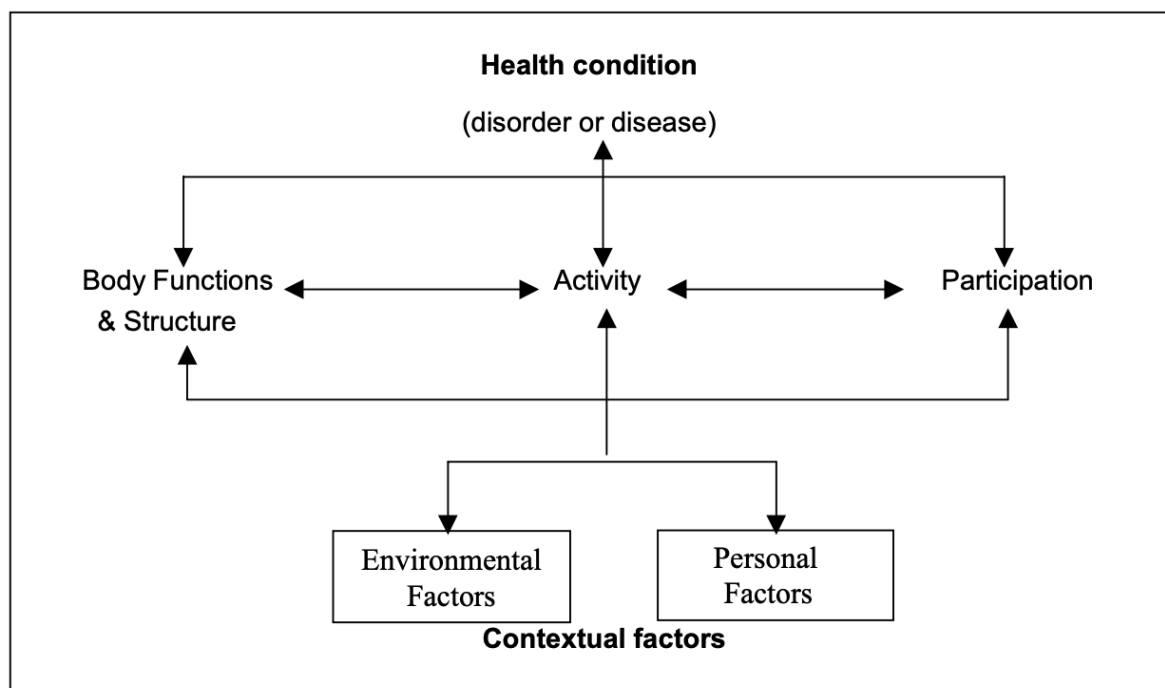
disability arises due to an inaccessible environment. From this perspective, it is social, attitudinal, and physical barriers that limit participation instead of the impairment itself (Llewellyn & Hogan, 2000). As the social model became more popular, it led to reflection within many healthcare fields, including speech and language therapy, about what assessment and intervention aims to achieve. For example, Duchan (2001) distinguishes between impairment-based assessment which solely aims to identify a person's difficulties, and social-based assessment which incorporates clients' personal goals, life experiences, communication barriers, and current strengths. Similarly, intervention informed by the social model places more emphasis on functional communication and environmental change. For example, a fluency intervention informed by the social model would focus on reducing stigma and environmental barriers to communication by working toward self-advocacy and participation rather than treating the dysfluency as a defect to be corrected (Bailey et al., 2014). These approaches reflect a broader focus on participation, autonomy, and accessibility, rather than just reducing impairment.

Although the social model of disability has been widely regarded as a pivotal and valuable framework, some critics argue that the model can overemphasise social aspects and underplay people's lived experiences with impairment, suggesting that not all challenges a disabled person faces are due to social barriers (Terzi, 2004; Shakespeare, 2014; Zaks, 2023). Worrall (2001) also argues that it can be difficult to completely separate a medical and social model approach in speech and language therapy, as clients' own goals often include a combination of skill development and environmental adaptation techniques to achieve. Consequently, some studies suggest that a more integrative framework is needed to account for both social barriers and impairment effects (Terzi, 2004).

The biopsychosocial model (Engel, 1977) is therefore often referred to by SLTs (Kwok et al., 2023). This model incorporates both the biological and social factors of the aforementioned disability models, along with the clients' perspectives of disability. The World Health Organization (WHO) released the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) and a corresponding version centred around children and young people (ICF-CY) (WHO,

2007) based on the biopsychosocial model (see figure 1.1). The ICF can be used both as a classification system and as a framework to guide clinical decision-making (Threats, 2008). McLeod and McCormack (2007) have provided a case study illustrating how an SLT might apply the ICF when working with a child with an SSD. For example, the therapist might use a standardised assessment to identify which sounds the child has difficulty producing and provide structured tabletop activities to practise these sounds. In addition, the SLT might observe how the child communicates in everyday contexts, such as during classroom discussions or play with peers. Therefore intervention might focus on supporting the child to improve their speech skills while also incorporating parent and teacher strategies to use in the classroom (McLeod & McCormack, 2007). As Threats (2008, p. 51) adequately summarises, “The philosophic approach of the ICF moves the client from being a passive receiver of health care and even beyond a participant, but to the actual centre of the efforts.”

Figure 1.1 *The ICF (WHO, 2001)*



1.3.3 Neuro-Affirming Practice

The topic of neurodiversity is closely linked to discussions of disability models, as it reflects broader shifts away from deficit-based views of differences toward perspectives that emphasise acceptance and environmental adaptation (Dwyer et al., 2025). Neurodiversity is difficult to concisely define due to differing perspectives of researchers, service users, and the general public (Dwyer, 2022). While it can be defined as the uniqueness of every person's mind, it is also used to describe an activist movement for the equal treatment, value and acceptance of people with neurological differences (neurodivergent people) without intent to change or "cure" them (Dwyer, 2022; Leadbitter et al., 2021). Neurodiversity is often associated with individuals with Autism and Attention Deficit/Hyperactivity Disorder (ADHD), who frequently present with communication differences. Therefore, many neurodiverse children are often referred to speech and language therapy (Gaddy & Crow, 2023). Neuro-affirming practice is when clinicians or educators value neurological differences without aiming to reduce autistic or neurodivergent traits and can include environmental adaptation or individualised interventions that promote wellbeing, participation, and skill development (Dwyer et al., 2025). Gaddy and Crow (2023) provide guidelines for how an SLT would implement neuro-affirmative assessment and intervention:

1. Validate all types of communication and do not see differences as deficits
2. Respect the child's autonomy
3. Include the child in goal setting
4. Consider and accommodate to sensory needs
5. Use neutral language and describe the person's strengths, rather than using deficit-based language

Both neuro-affirming practice and social models of disability emphasise the importance of valuing different ways of communicating and functioning, and of adapting environments and expectations to support participation. In this view, the goal of intervention is not to change the child but also to reduce communication barriers, build on strengths, and promote acceptance of communication differences.

1.3.4 Family-Centred Practice

Family-centredness is a model of practice where the healthcare provider respects the beliefs and values of the client and their family, centring them in all clinical decision-making (Dunst, 2002). Family-centred practice involves the SLT sharing their clinical expertise regarding the family's assessment/intervention options, understanding that the family's expertise on their child's needs are equally valid and important, and joining these expertise to support the family to make their own informed decisions (Dunst, 2002). Family-oriented practice originates from family-systems theory, which recognises the impact a child's family has on their development (Mandak & Light, 2018b), and occurs on a spectrum (Biggs et al., 2024; Dunst et al., 1991):

1. Professionally-centred: the SLT is viewed as the expert, and completes all planning and goal-setting based on the child's assessment, without input from families on their own perspectives or goals. The professionally-centred SLT holds the belief that families need help in order to improve functioning.
2. Family-allied: families are minimally involved when the SLT deems it necessary. Family-allied SLTs bring their expertise to "teach" families techniques and strategies, and believe that families are capable of effecting change however only under instruction from the SLT.
3. Family-focused: families and SLTs collaborate to make goals and participate in decision-making. Family-focused SLTs move away from "teaching" or "training" parents and toward a coaching approach by listening to their concerns and discussing solutions.
4. Family-centred: the family's needs drive all aspects of the service and SLTs are agents of support. The SLT provides education on communication and intervention options but acknowledges that families are the experts on their life and are the key decision-makers.

Although this concept was developed over three decades ago and many best practice guidelines in different countries express the need for centring children and their families in decision making (ASHA, 2016; IASLT, 2023; RCSLT, 2018), recent studies show that family-centred practice is not always the norm (Biggs et al., 2024),

particularly in services for older children (Dunst, 2002; Mandak & Light, 2018a). Additionally, there is a discrepancy between SLT and parent beliefs in how often family-centred practice is provided, with SLTs reporting to provide more family-centred care than parents report receiving (Dunst, 2002; Mandak & Light, 2018a). This discrepancy may be due to challenges reported by SLTs such as not having time, restrictions of the practice setting, lack of training, and parents having opposing views (Mandak & Light, 2018b). There also appears to be a belief among some clinicians that family centredness equates to attendance, adherence, and agreement, rather than involvement in discussion and joint decision making (Mandak & Light, 2018a, 2018b).

It must also be noted that among much of family-centred research, there is a heavy focus on the parents' involvement in intervention processes (McCarthy & Guerin, 2022). However, incorporation of other influential people in the child's life is also important, such as siblings, grandparents, wider family, and vitally, the child's own perspectives (Mandak et al., 2017; Purssell & Sagoo, 2023). Consideration of family-centred principles when deciding what to target in intervention has shown to have many benefits such as building positive relationships, generating trust, improving child outcomes, and better satisfaction with the service (Mandak & Light, 2018a).

1.3.5 Therapeutic Alliance

Putting family-centred principles into practice often depends on developing a strong therapeutic alliance between the clinician, child, and family. Therapeutic alliance, commonly referred to as rapport or therapist-client relationship, refers to the interactional and relational processes that occur between a therapist and client (Connery et al., 2022). Although it took its roots from the psychology field, collaborative therapeutic relationships have long been recognised as central to speech and language therapy practice. More recently, the term “therapeutic alliance” has been increasingly used within SLT literature, particularly in areas such

as stuttering (Byrne & Connery, 2023; Connery et al., 2022) and aphasia (Lawton, Haddock, et al., 2018; Lawton, Sage, et al., 2018).

A range of clinician, client, and external factors can facilitate or hinder the development of a positive therapeutic alliance (Connery et al., 2022). In terms of therapist qualities, being empathetic, confident, empowering, engaging in active listening, and seeing the client as a person rather than a condition were identified as important traits and behaviours by service users (Byrne & Connery, 2023; Fourie, 2009; Lawton, Haddock, et al., 2018). Ebert and Kohnert (2010) further describe that clinician factors such as motivation, patience, flexibility, communication skills, and ability to avoid biases can be as influential on client outcomes as the intervention method used. Therapeutic alliance is also shaped by clients' readiness to engage honestly with therapy and to navigate the changes and responsibilities it entails (Byrne & Connery, 2023; Lawton, Haddock, et al., 2018). Factors such as time limitations, medically oriented models of care, and the availability of social supports can constrain or enable opportunities for collaboration and shared understanding (Connery et al., 2022; Lawton, Sage, et al., 2018). These findings suggest that therapeutic alliance is an important means of allowing service users and clinicians to share their perspectives, and should be considered alongside research evidence and service delivery factors to carry out family-centred and evidence-based practice.

1.3.6 Theories of Change

Finally, speech and language therapy intervention is often about effecting change, whether that be in supporting the individual's innate capabilities or changing the environment to optimise function and participation. Understanding how change happens can be helpful in thinking about the therapeutic process. Several theories have been developed which attempt to explain key processes of change (see Table 1.2). Some theories, such as the Transtheoretical Model of Change (Prochaska & DiClemente, 1983), focus on aspects related to the individual, such as their readiness for change and progression over time. Other theories, such

as the Self-Determination Theory (Deci & Ryan, 1985), and the Theory of Planned Behaviour (Ajzen, 1991) adopt a broader perspective as they also consider how social norms, external influences, and perceived capability can influence engagement in behaviour change. Although some of these theories were developed several decades ago, they remain influential because their core principles continue to be supported by current research (e.g., Castro et al., 2024; Van Leer et al., 2008). Finally, broader frameworks such as the Behaviour Change Wheel (Michie et al., 2011) and Theoretical Domains Framework (Michie et al., 2005) incorporate wider service- and policy-level factors. These frameworks were developed to help clinicians, organisations, and policymakers design interventions and systems that support EBP implementation and inform policy-level change (Michie et al., 2005;2011). Although often applied at professional or organisational levels, they can also provide useful insights into how behaviour is shaped within complex clinical contexts. In speech and language therapy, these theories can help explain how children and families engage with intervention, sustain new behaviours over time, and generalise skills to everyday situations. Table 1.2 below summarises these key theories.

Table 1.2 Theories of Change

Theory	Key Idea	Steps/Components	Level of Change	Example connection to SLT
Transtheoretical Model (Prochaska & DiClemente, 1983)	Behaviour change occurs in stages	Stages: 1. Precontemplation: unaware change is needed 2. Contemplation: aware but no action. 3. Preparation: intention to change and initial steps taken 4. Action: actively changes behaviour 5. Maintenance: sustains changes over time	Individual	Identifying whether a child is ready to receive home practice or still unsure about its value
Self-Determination Theory (Deci & Ryan, 1985)	Motivation depends on 3 psychological needs and occurs on a continuum	Needs: • Autonomy: sense of choice • Competence: feeling capable • Relatedness: connection with others Motivation continuum: ↓ External: rewards/punishment ↓ Introjected: guilt/pressure ↓ Identified: personal value ↓ Integrated: aligned with values ↓ Intrinsic: enjoyment/interest	Individual and social	Following the child's lead in a therapy session and incorporating communication goals into their chosen activities.
Theory of Planned Behaviour (Ajzen, 1991)	Three main factors predict an individual's intention or behaviour	Factors: • Attitude: beliefs about expected outcomes • Subjective norms: social approval or pressure • Perceived control: ease/difficulty of new behaviour	Individual and social	Addressing a parent's beliefs about whether they can realistically carry out daily home practice

Theoretical Domains Framework (Michie et al., 2005)	12 domains should be satisfied to implement change	Key domains: 1. Knowledge 2. Skills 3. Social/professional role and identity 4. Beliefs about capabilities 5. Beliefs about consequences 6. Motivation and goals 7. Memory, attention and decision processes 8. Environmental context and resources 9. Social influences 10. Emotion 11. Behavioural regulation 12. Nature of the behaviour	Individual and organisational	Identifying organisational barriers, such as limited time, training, or resources, that affect how SLTs implement evidence-based intervention approaches
COM-B / Behaviour Change Wheel (Michie et al., 2011)	Wheel with three layers which summarise behavioural, intervention, and policy requirements for change	Wheel Layers: • Inner behaviour layer (B): change occurs when three conditions are present—Capability (C), Opportunity (O), and Motivation (M) • Intervention layer: categories of strategies used to address behavioural barriers or facilitators • Policy layer: wider system and policy factors influencing implementation and sustainability	Individual and system	Designing services and policies that increase SLTs' and families' capability, opportunity, and motivation to engage in intervention

1.4 Service Challenges

The theories and models of practice discussed in this chapter have been influential in speech and language therapy service and practice development. However, this combination of different influences and how they interact with practical realities of how services are currently set up appears to lead to inconsistencies in practice across the profession. For example, services that were originally established within medical-model contexts may contribute to the mismatch between how much SLTs feel they are practising family-centred care and the reality that practice often remains more professionally centred (Biggs et al., 2024). Similarly, external pressures to deliver intervention at a certain intensity may limit clinicians' ability to invest time in developing rapport and collaborating extensively with families to ensure that goals are meaningful and neuro-affirming (O'Toole et al., 2025).

Secondly, there are additional challenges due to practical challenges families face when trying to access services. Taking the Irish context for example, 12,912 children were awaiting initial contact with their disability network team in April 2025, with approximately two thirds waiting over a year. Similarly, almost 19,000 children were waiting for an initial assessment for speech and language therapy, with over 500 remaining on the waiting list for over a year (Sherlock, 2025). While waiting lists and service access has been a longstanding issue in children's therapy in the Irish context, these challenges were exacerbated by the health service's response to the Covid-19 pandemic, which involved shutting down services and redeploying SLTs to Covid-19 testing and contact tracing (Müller et al., 2023). Although services have returned, they remained understaffed, with vacancy rates reaching 45% in some areas of Ireland (IASLT, 2024). SLTs continue to report dissatisfaction in their working environment, explaining that excessive caseload sizes are reducing their ability to provide quality interventions, negatively impacting client-therapist relationships and severely demoralising clinicians (O'Toole & O'Leary, 2025). In these challenging services, SLTs may seek alternative ways to increase intervention dosage that cannot be achieved through direct therapy, such as introducing home practice or providing families with larger amounts of resources in

an effort to maximise support. While these approaches may be a pragmatic responses to service pressures, they do not always reflect EBP or be what is most effective or sustainable for families. Healthcare policies such as Sláintecare, which aim to address service pressures, also promote service-user self-management (Houses of the Oireachtas, 2017). However, greater consideration is needed regarding how clinicians can support families to engage in home practice and self-management in ways that are both evidence-based and feasible within everyday life. These issues are explored further in the following chapter.

1.5 Chapter 1 Summary

Speech and language therapy can help children with SLCN to reach their full potential and improve communication, social, and educational outcomes (Broomfield & Dodd, 2011; Law et al., 2005; Liu et al., 2025; RCSLT, 2024a). SLTs work with children with SLCN across a range of service delivery structures, such as directly or indirectly, in different settings, and at different intervention intensities (Ebbels et al., 2019; IASLT, 2023; Warren et al., 2007). Many models and theories have influenced the way speech and language therapy is delivered over time, such as models of disability, family-centred care, neuro-affirming practice, and theories of change. Although decisions about service delivery and intensity aim to be evidence-based, the influence of evolving models means that evidence and preferred approaches continue to change, resulting in inconsistencies between what is considered best practice and current realities. Additionally, SLTs and families face many service challenges such as long waiting lists and excessive caseload size which influence how services are delivered (Bermingham, 2022; O'Toole et al., 2025). SLTs are often challenged to think of alternative ways to increase the child's practice dosage, while also considering how intervention is generalised to meaningful contexts and empowering families to feel actively involved and in control of their care. Greater consideration is needed regarding the practical realities of achieving this.

Chapter 2: Home Practice

Home practice, a common speech and language therapy component, is often utilised with the goal of increasing practice dosage, support family engagement and facilitate generalisation (Tosh et al., 2017). This chapter defines the concept of home practice, explores common home practice approaches, and critically evaluates its evidence base.

2.1 Definition of Home Practice

Multiple terms have been used to describe the practice of providing families with activities, techniques, and strategies to implement with their child outside therapy appointments. Terms include “parent-implemented therapy” (DeVeney et al., 2017), “home practice” (Sugden et al., 2019), “homework” (Watts Pappas et al., 2008), and “carryover activities” (Doherty et al., 2025). The plethora of names likely reflects the conceptual differences amongst therapists and researchers on what home practice actually is. Home tasks and activities in speech and language therapy can be broadly grouped into two main categories:

- 1) Parent-implemented tasks provided to families accessing indirect intervention: This approach generally involves the SLT coaching family members on using communication-enriching strategies during interactions with their child, along with discussing environmental changes that may enhance interactions (DeVeney et al., 2017). The child is not directly involved, rather a receiver of strategies carried out by others.
- 2) Activities assigned to families as a supplement to direct intervention: the child themselves completes tasks or practice strategies, with the support of family or other communication partners between therapy sessions (Doherty et al., 2025).

This thesis focuses on the latter group, and going forward “home practice” will be the term used to refer to activities completed outside the clinic environment

directly with the child, who is knowingly engaging and participating in the activities. For example, SSDs are often treated with traditionally clinician-implemented approaches such as traditional articulation therapy or phonological contrast approaches, with dosage increased through home practice (Dodd, 2014). Vocabulary, grammar, and narrative skills are often developed through explicit teaching techniques by the SLT, who also guides parents and teachers on supporting the child's learning at home or in school using these teaching techniques (Rinaldi et al., 2021). Vignette 1 and 2 later in this chapter provide concrete examples of what home practice might look like for children with SLCN accessing direct therapy.

2.2 Home Practice Implementation

Although home practice is widely used in speech and language therapy, less is known about how it is implemented in everyday clinical contexts and how families experience this process. The following section summarises available research on current practices in assigning, supporting, and monitoring home practice, alongside the challenges reported by both clinicians and parents.

2.2.1 How Home Practice is Assigned

Two large-scale surveys done in Australia found that an overwhelming majority of therapists (97% and 95% respectively) recommended home practice to parents of children with SSDs (Watts Pappas et al., 2008; Sugden et al., 2018). A smaller, but still majority, 60% of SLTs in the US reported assigning home practice for the same group always or most of the time (Tambyraja, 2020). Doherty et al.'s (2025) survey looked more widely across the profession where 84% of parents reported receiving home practice and 96% of SLTs reported providing it. Common forms of home practice include games and activities, worksheets, drill-based tasks, online activities, and activities which are embedded into everyday routines (Sugden et al., 2018). Home practice is usually provided to parents verbally, but also can be assigned via written instruction, through tangible resources provided to parents, and

occasionally through online tools or apps (Doherty et al., 2025). Time spent on home practice varies, with short, frequent practices being preferred (Sugden et al., 2018).

2.2.2 How Home Practice is Supported

SLTs and parents have described numerous strategies that support families with the delivery of home practice. Allowing parents to observe the SLT delivering strategies, providing opportunities for practice during sessions with feedback from the therapist, and encouraging reflection after implementing home practice were all described as supportive strategies (Doherty et al., 2025; Sugden et al., 2018). Explaining the rationale for home practice, emphasising the benefits of parent involvement, and discussing expectations of both the SLT and family members roles in intervention and home practice were also thought to improve family's experience and involvement (Tambyraja, 2020), with parents in Sugden et al.'s study (2019) adding that the inclusion of the wider family network being beneficial. One valuable method that continuously appeared in literature was the incorporation of home practice into the family's home life and daily routine (Doherty et al., 2025; Tambyraja, 2020; Sugden et al., 2018; Sugden et al., 2019; Tambyraja, 2020). In order for an SLT to understand if home practice is being successfully integrated into family routines and is working well with the family's lifestyle, continuously checking in with families on their progress and concerns is vital.

2.2.3 How Home Practice is Monitored

Aspects of home practice that can be monitored are completion rates, factors impacting completion, challenges encountered, progress being made by the child or family members, and confidence completing it (Doherty et al., 2025). SLTs use a number of methods to monitor home practice such as verbal check ins, providing a log or checklist, and occasionally a technology platform (Doherty et al., 2025), with many SLTs finding that these methods are subjective and unreliable (Tambyraja, 2020; Rvachew & Brosseau-Lapre, 2015). Home practice monitoring does not appear consistent, with 66% of parents in Doherty et al.'s (2025) survey

reporting that their SLT checked in about their tasks, and only 43-76% of SLTs in another study reporting to consistently follow up with families (Doherty et al., 2025; Tambyraja, 2020). Monitoring home practice under a family-centred approach should include evaluating if the given tasks were working with family's unique lifestyle and making necessary adjustments to ensure it is realistic, achievable, and not putting unnecessary emotional strain on the family. However, some SLTs expressed that the purpose of home practice monitoring is to determine and evaluate parental buy in, engagement, and accountability (Doherty et al., 2025), appearing to disregard the parent's choice in their level of engagement (Watts Pappas et al., 2008), possible challenges encountered by families, and their role in supporting them during these challenges (Sugden, 2019).

Figure 2.1 *Vignette 1: Home Practice for DLD*

Child profile: Julia is nine years old with a diagnosis of developmental language disorder. She attends speech and language therapy with her dad once a week. Her current goal is to build her vocabulary through a narrative approach.

Intervention: Julia brought one of her favourite books from home into the session. She read an excerpt of the book with her SLT and identified three words she was not familiar with. A word map was completed for each word, including a child-friendly definition, synonyms, antonyms, an example sentence, and a drawing to support understanding. During the session, the SLT noted that Julia was having difficulty remembering the difference between synonyms and antonyms.

Home practice: The SLT provided Julia with two A4 worksheets on synonyms and antonyms. She also suggested using her new words in conversations throughout the week.

How it was assigned: the SLT showed Julia and her dad the worksheets and verbally explained how to complete it. The instructions were also included on the page. The SLT gave Julia's dad some examples of how they might use their new words and encouraged him to use each new word a few times during general conversation to consolidate her learning.

How it was monitored: at the following session, the SLT reviewed the worksheet and asked both Julia and her dad about parts that were useful or challenging. Julia was asked about the meaning of last week's new words and found that she had remembered all definitions. Similar quantity and style of homework was given again.

2.2.4 Home Practice Challenges

Parents of children with SLCN have expressed many challenges associated with home practice. For example, parents often enter services with different expectations of their role in intervention than SLTs, leading to frustration when unexpectedly provided with an overwhelming amount of tasks (Phoenix et al., 2020). While many SLTs have acknowledged the importance of discussing expectations and roles prior to beginning intervention and home practice (Doherty et al., 2025; Watts Pappas et al., 2008), parents in another study reported that this was not a discussion they had with their SLT (Sugden, 2019). Similarly in Klatte et al.'s (2024) study, some parents felt that their relationship with their SLT was mostly one-way, describing professionally-centred SLT behaviours such as making decisions without parental input and giving instructions that are unclear. Without incorporating the family's input, home practice cannot be suited to the family's needs, leading to practical issues such as not having time to complete home practice, difficulty remembering tasks, and children not being interested or engaged (Doherty et al. 2025; Sugden et al., 2019). These accumulating challenges can lead to parents experiencing the emotional load that occurs when feeling unsuccessful in home practice completion, as they have described feelings of guilt, overwhelm, frustration, and worry (Doherty et al., 2025; Sugden et al., 2019). It is clear that parents want to be involved but face numerous challenges in feeling confident and successful in doing so, pointing to a disconnect between parent and SLT perspectives of how home practice is being supported.

Contrary to parent's desire to support their child's development, SLTs often report that parental engagement is the biggest challenge in speech and language therapy home practice (Doherty et al. 2025; Watts Pappas et al. 2008; Tambyraja, 2020). Parent engagement is interpreted in many ways such as attendance, active involvement, participation in sessions or at home, along with a willingness, readiness, and motivation to participate in intervention (Melvin et al., 2020). Watts Pappas et al. (2008, p. 339) reported that 75% of SLTs felt that parents "should be able to find the time to do homework activities with their child", which does not acknowledge the previously described challenges faced by parents. Some SLTs also

believed that they could gauge parent engagement through how much progress the child made, disregarding the complex range of factors that influence therapeutic outcomes beyond parental effort (Doherty et al., 2025). There also appears to be a gap between family-centred best practice and SLT's perceptions and actions, with less than half of SLTs in the same study reporting that they allow parents to make final decisions on goals, interventions, or level of involvement (Watts Pappas et al., 2008).

This misalignment raises questions as to why SLTs are not providing individualised, family-centred home practice. Some practical challenges are faced by SLTs in supporting family engagement in home practice such as restrictions placed by their place of work (particularly school-based SLTs), large caseloads and high pressure not giving enough time to organise home practice, and a lack of confidence in assigning and managing home practice (Doherty et al. 2025; Watts Pappas et al. 2008). The family-centred guidance from research and literature may not have been translated to clinical practice due to these service challenges, the delay between research being published and uptake in clinical practice (Morris et al., 2011), and a lack of training for qualified SLTs in how to make changes to their delivery approach (Mandak & Light, 2018b). However, many factors such as government initiatives for self-management (Houses of the Oireachtas, 2017), family-centred guidance for SLTs (Biggs et al., 2024), and research on parent experiences of home practice (Doherty et al., 2025; Sugden et a., 2019) all indicate that supporting families in decision-making and involvement should be a fundamental part of therapy rather than an optional addition.

Figure 2.2 *Vignette 2: Home Practice for an AAC User*

Child profile: Theo is twelve years old with a diagnosis of cerebral palsy and uses AAC (speech generating device) as his primary means of communication. He attends a community-based disability speech and language therapy service. His current goal is to increase his independence in initiating comments during social interactions with family and peers.

Intervention: During a therapy session, Theo shared that he wanted to contribute more to conversations at lunchtime with friends and dinnertime with family but finds it hard to find the buttons quickly before the conversation moves on. The SLT and Theo came up with some commonly used phrases (e.g., “that’s cool”, “me too”, “give me a second”) and set up buttons in a new folder called “meal chats” for quick access.

Home practice: practice using comments at dinner time with family.

How it was assigned: The SLT supported Theo to choose when he wanted to practice. Theo’s parents were also given a verbal explanation of the practice and how to support him by allowing wait time and responding naturally.

How it was monitored: At the following session, the SLT spent the first 10 minutes discussing the home practice with Theo and his parents. Theo used his AAC device to report how often he practised and which situations felt easiest. The same home practice was continued, with one additional comment phrase selected by Theo.

2.3 Role of Coaching in Home Practice

It is evident that there is a considerable disparity between what is described as supportive of family involvement in home practice and the actual experiences of many parents and SLTs in completing, supporting, and monitoring home practice. One way that could potentially improve how home practice is utilised is the improvement of coaching provided by the SLT. Currently, home practice provided in addition to direct therapy appears in many instances to be quite therapist-driven. Some coaching techniques can be drawn from parent-implemented therapy, such as the teach-model-coach-review method which reinforces principles of viewing

families as the central part of intervention and SLTs as a guiding support (Kaiser & Roberts). However, learning from the parent and SLT challenges described above highlights other key components that should be implemented to improve home practice experiences. Adopting a family-centred model for home practice would require that SLTs incorporate family input from the beginning, discussing what is realistic, achievable, and fits into family lifestyle (Biggs et al., 2024). Providing a safe and empathetic space to troubleshoot challenges, brainstorm solutions, and suggest adaptations to home practice could allow SLTs to move away from a teaching approach and toward a coaching style which tailors home practice to each individual child (Biggs et al., 2024; Doherty et al., 2025). Involving multiple family members in decision-making, intervention, and home practice could also relieve the stress faced by some parents (Sugden et al., 2019). SLTs in practice may encounter challenges adapting a coaching approach such as the lack of support for SLTs in moving toward family-centred practice, and lack of research completed with these wider family members.

2.4 A Missing Perspective

All of the studies exploring perspectives of home practice included in this chapter have investigated either parent or SLT perspectives on the subject. Some parents have provided proxy reports of how their children managed the home practice in which they were involved, for example that a rapport between the child and SLT motivates children to complete home practice, and that the type of materials provided can make or break child engagement (Sugden et al., 2019). However, further examination is needed to better understand how children themselves perceive home practice and what they identify as facilitating or hindering their involvement.

Chapter 3: Conducting Research with Children

3.1 Introduction

While chapter two summarised the available evidence-base for home practice in speech and language therapy, it highlighted a critical gap within the literature. Children's voices in research on this topic are notably absent. This chapter delves into the importance of involving children in research, principles that guide research in child participation, and introduces some emerging research with children in the speech and language therapy field.

3.2 Background of Childhood Research

Researching children's perspectives is not a new concept, it has been evident in literature for over a century (Hogan & Gilligan, 1997). However, the rationale and methods used to include children in research has evolved throughout the years as sociological viewpoints of childhood have progressed. Children were historically viewed as smaller, 'incompetent' adults, with their views of society seen as less valuable than those of an adult (Gallacher & Gallagher, 2008). Research about child-related topics was therefore conducted through an adults perception, either through the use of proxies such as parents (Carter, 2009) or ethnographic research analysed through the adult researcher's lens (Gallacher & Gallagher, 2008). There was a shift in thinking in the 1990s where children were beginning to be conceptualised as active participants of their own lives, with cultures and social structures different to that of an adult (Prout & James, 1990). Social research methods evolved with this line of thinking to allow children to express their unique views, with 'participatory methods' becoming more popular (Gallacher & Gallagher, 2008). There are different definitions of participatory methods (Sevón et al., 2023), from researchers providing accessible, flexible and fun techniques to nurture the child's individuality and creativity (e.g., Clark, 2017), to involving children in the research process and supporting them to become co-researchers (e.g., Lundy et al., 2011). Within speech and language therapy, research has demonstrated that preschool children can

express their views on intervention when appropriate methods, such as analysing body language, visual attention, and vocalisations (Roulstone et al., 2015). Similarly, school-aged children and adolescents have reflected on their experiences of therapy and specialist provision, highlighting the value of incorporating children's perspectives within research and practice (Owen et al., 2004; Simkin & Conti-Ramsden, 2009). Although these different approaches may have varying aims, interest into how children view their worlds has generally been on the rise (Gallacher & Gallagher, 2008).

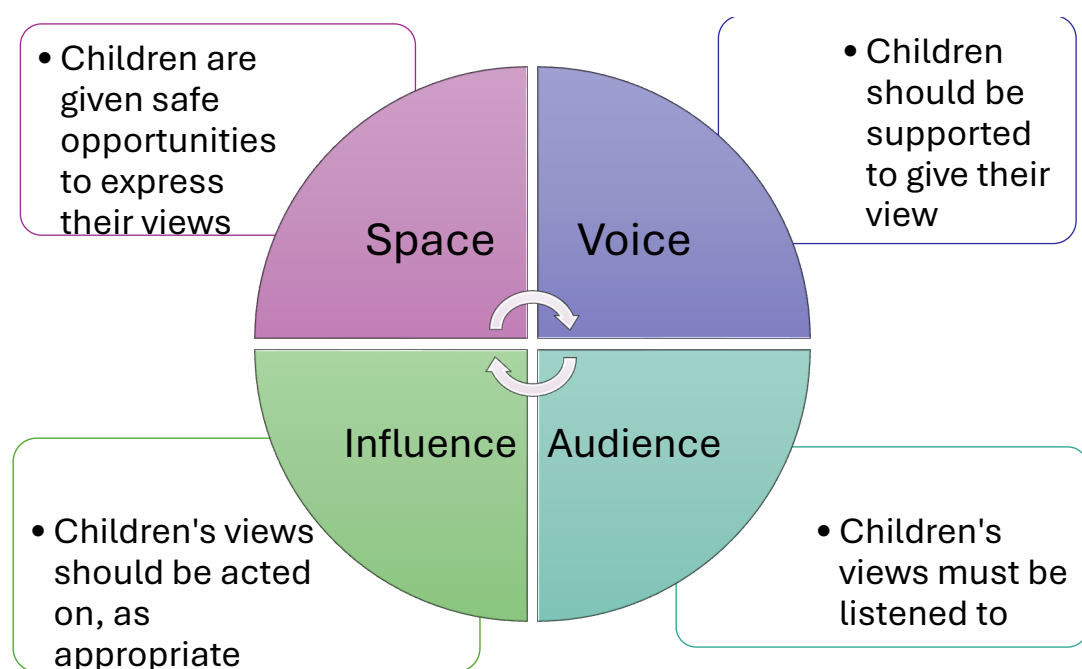
It is not only a growing interest for adults to listen to children's views in research, it is also a fundamental right of every child. Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) states that children have the right to freely express their views on matters concerning themselves and that these views should be taken into account in accordance with their age and maturity (United Nations, 1989). Ireland, having ratified the UNCRC in 1992, have also incorporated this right into numerous policies and frameworks. For example, the Irish government released the National Strategy on Children and Young People's Participation in Decision-Making which detailed objectives such as maximising children's participation in policy development and research (Department of Children and Youth Affairs, 2015). The "Young Ireland" policy framework was subsequently released, working toward eliminating challenges children face in exercising their rights, while embedding children's views in the actions taken to reach this goal (Department of Children Equality Disability Integration and Youth, 2023). Academics in paediatric fields are therefore encouraged to consider children's views in their research. However, recruitment to a research study without careful consideration of how to collect and use information gathered from children does not necessarily result in the child fully exercising their right to be heard, and researchers should consider methods which make participation inclusive, accessible, and supportive of children expressing their views.

Lundy (2007) provides a useful model to ensure that the two elements of UNCRC article 12 are realised; both supporting children to express their views and ensuring those views are properly considered. The model provides four key concepts for

adults working with children to consider, which will be discussed specifically in the research context (see figure 3.1):

1. **Space:** research should strive to consider children's views, and ensure that children have safe opportunities to speak truthfully. Complex power dynamics exist between researchers and child participants (Robb, 2023). Therefore ethical considerations have developed as more is understood on gaining assent and promoting open, honest engagement (see Oulton et al., 2016 and Chapter 7 for a discussion).
2. **Voice:** researchers should facilitate the collection of their views in a manner appropriate to the child's developmental and communicative profile. A range of methodologies have been developed in recent years to help researchers support children's expression (Sevón et al., 2023).
3. **Audience:** researchers should actively listen to children's responses and disseminate research results with the appropriate people, for example, policy makers or speech and language therapists working with children.
4. **Influence:** children's views should be given due weight, and incorporated into decision-making processes concerning them.

Figure 3.1, Adapted from *Lundy's Model (2007)*



Challenges appear to be common in the last two elements of this model, for example, the long time it takes for research to reach clinical practice (Morris et al., 2011) and ensuring everyone's point of view is considered fairly (Bird et al., 2013). Despite these challenges, prevalent sociological views on childhood research, universally recognised children's rights, and guidance such as Lundy's Model (2007) provide rationale and guidance for researchers to explore children's perspectives on topics relevant to them.

3.3 Research with Children in the Speech and Language Therapy Field

There is a growing body of research that seeks to understand the experiences of children with SLCN by placing emphasis on their own perspectives. Some of this literature looks into how communication differences shape children's self-perception, sense of identity, and quality of life, recognising that communication plays a central role in how children understand themselves, relate to others, and participate in everyday life. Research in this area highlights children not only as recipients of support, but as individuals with their own interpretations of their abilities, challenges, and social worlds. This section therefore reviews this literature to give essential context for understanding how children perceive their experiences, which is foundational when considering their engagement with therapy, service delivery, and home practice later in this thesis.

3.3.1 Perception of Communication and Self-Image

Some studies aimed to investigate how children with SLCN perceive their communication difficulties. McCormack et al., (2010) interviewed preschoolers and their family members to understand the impact of SSDs on everyday life. Both the children and their family members identified that communication difficulties arise from both the speaker's difficulty and the listener's challenge in understanding them. Older children shared a similar view of speech and language difficulties (Merrick & Roulstone, 2011). They viewed communication difficulties as a problem

within themselves, but also alluded to the attitude of peers and fear of being “picked on” as a barrier to participation. Lyons & Roulstone (2017) investigated the labels that children with primary speech or language difficulties used to describe their difficulties. The authors were inspired by recent changes and debates on new terms used in the field, such as “developmental language disorder” (Bishop et al., 2017) and noted that children’s views on the topic were not consulted. Findings showed that some children labelled themselves with other diagnoses like ADHD or dyslexia, but they did not use any specific labels about their speech or language difficulties, perhaps reflecting the lack of awareness in the general public on communication difficulties compared to other diagnoses. However, they were aware of some labels placed on them by others and associated some labels like “special” with stigma and dislike.

Other studies focused more on children’s perceptions of themselves and how their needs impacted self-image. Some children had negative perceptions of themselves due to their communication difficulties (Owen et al., 2004). They associated their difficulties with embarrassment, anxiety, fear of standing out, and feeling less intelligent than peers (Owen et al., 2004). However, not all self-perceptions were negative. For example, Palikara et al. (2009) reported that one quarter of teenagers shared similar views as the children in Owen et al.’s (2004) study, feeling upset, frustrated, or ashamed of seeking support. However, the other three-quarters felt that they had come to terms with their difficulties, with some feeling a sense of achievement for overcoming their difficulties throughout their time in education. Many appeared optimistic about their future, hoping to pursue further education or employment (Palikara et al., 2009). Self-image was also discussed in Clarke et al.’s (2001) study with AAC users, and found mixed responses from children. Many echoed the embarrassment of being perceived as different, while others felt that their AAC device was a part of themselves and their identity.

Findings from these studies raise an interesting discussion on how children experience communication disability. Children talked about their communication difficulty in terms of impairment and societal barriers (McCormack et al., 2010; Merrick & Roulstone, 2011), and often compared themselves to typically developing

peers in either positive or negative ways (Clarke et al., 2001). Very similar views were found in Connors and Stalker's (2007) study investigating disabled children's life experiences. Children in this study preferred to focus on similarities shared with their peers without disability, but reported that negative attitudes from others and material barriers such as lack of accessible environment and communication supports made them feel different and lesser than (Connors & Stalker, 2007). The authors hypothesise that disabled children may focus on a sense of "sameness" to avoid negative attitudes of others, counteract negative stereotypes, or because they lack a positive representation of being different. These findings show that although healthcare may be shifting to a social model of disability, societal realities show that more can be done to support children with disabilities, including those with SLCN.

3.3.2 Children's Perceptions of their Quality of Life

A few studies reported on the impact of SLCN on quality of life, mainly through discussion about impairment, relationships, and achievement.

Firstly, the theme of impairment arose as a barrier to quality of life for many children with communication difficulties. Many children discussed that experiencing communication difficulties can elicit negative emotions. Sadness, anxiety, worry, and frustrations were some emotions children attached to having to deal with their impairment (Lyons & Roulstone, 2018; Markham et al., 2009). Impairments can sometimes lead to children relying on their parent or communication partner to communicate on their behalf, which can be demoralising (McCormack et al., 2010). Oppositely, children reported that being supported to attain independence positively impacted their quality of life. Children valued having autonomy in how they dealt with communication breakdowns, relationship difficulties, implementing strategies they have learnt, and carrying out everyday skills (Lyons & Roulstone, 2018; Markham et al., 2009).

Secondly, relationships with family and peers consistently appeared as both a barrier and enabler of quality of life. Children with SLCN described challenges they

face with making and maintaining relationships with others. Unfortunately, children in Lyons et al. (2018) study reported that their communication difficulties resulted in them not being able to make many friends and in some cases led to verbal or physical bullying. Similar social difficulties were reported by children across many studies (Markham et al., 2009; Owen et al., 2004; Roulstone et al., 2012b). That being said, positive relationships were also repeatedly referred to by children as a factor that improved their wellbeing (Lyons & Roulstone, 2018; Owen et al., 2004; Palikara et al., 2009; Roulstone et al., 2012b). For example, some children valued participation and inclusion in sports teams (Markham et al., 2009), some communicated appreciation to their parents looking after them (Palikara et al., 2009) and others put emphasis on friends who stood up to bullies with them (Lyons & Roulstone, 2018).

Lastly, achievement was a common theme among studies as both a barrier and enabler of positive quality of life. In terms of risks to wellbeing, concern about academic achievement such as finding schoolwork difficult and anxiety about falling behind in school were highlighted by some children (Lyons & Roulstone, 2018). Children's concern about their achievements was not constrained to within the school environment, as they also reported concerns about not excelling in extra-curricular activities such as games with friends, due to their communication difficulties (Markham et al., 2009). Children still valued and desired academic and non-academic achievement, despite the challenges they faced. They acknowledged that they had to overcome extra hurdles to achieve success, and this appeared to instil a sense of pride and fulfilment among some (Markham et al., 2009). Hope and optimism for future success was a theme among many studies, demonstrated by aspiration to follow careers that interested them (Lyons & Roulstone, 2018; Palikara et al., 2009; Roulstone et al., 2012b). Evidently, there are common factors that influence children with SLCN's quality of life, however individual's views can be highly varied depending on their experiences and perspectives of the services and supports provided to them.

3.4 Next Steps for Childhood Research in Speech and Language Therapy

This literature demonstrates that children with SLCN perceive their communication differences in ways that shape their self-perception, relationships, aspirations, and overall quality of life. Children's accounts highlight the emotional, social, and practical consequences of communication difficulties, as well as the importance of supportive relationships, positive experiences, and opportunities for achievement. Children clearly showed their ability to express their views when supported by inclusive research methods, which emphasises the importance of frameworks such as Lundy's Model (2007) and ensures children's voices influence decisions that affect them (United Nations, 1989).

While research has increasingly sought to understand how children experience their communication difficulties, there remains a need to examine their perspectives of speech and language therapy itself. Aspects of service delivery such as how intervention is accessed and supported, alongside how children and families are included in decision-making and home practice, may also have implications on how children experience their communication difficulties, therapy, and overall participation in daily life. Exploring children's views in these areas is therefore an important next step for childhood research in speech and language therapy, and provides the rationale for the research aims of the present study.

3.5 Research Aim

This study aims to explore children's views of speech and language therapy home practice from their own perspective. Home practice is widely used within speech and language therapy services (Doherty et al., 2025). However, existing research has predominantly focused on the views of adults, including clinicians and parents, and even still remains limited. Additionally, children's perspectives remain underrepresented in research in general, despite the importance of listening to their voices to uphold their rights, carry out EBP, and conduct family-centred care (Lyons et al., 2022). Gaining children's insights is therefore essential to develop a more

comprehensive understanding of home practice and address a clear gap in the literature.

Reflection on the literature presented earlier highlights that home practice does not occur on its own, but represents one component of speech and language therapy service delivery, closely linked to factors such as dosage, therapy structures, family involvement, and therapeutic relationships. As a result, understanding children's views of service delivery more broadly provides important context on how home practice is experienced and how it interacts with other aspects of therapy. To address these interconnected topics, the study was designed around two more specific research questions:

- 1) What are children's perspectives of speech and language therapy service delivery?
- 2) How do children experience home practice, and what do they perceive as barriers and facilitators to engagement in home practice?

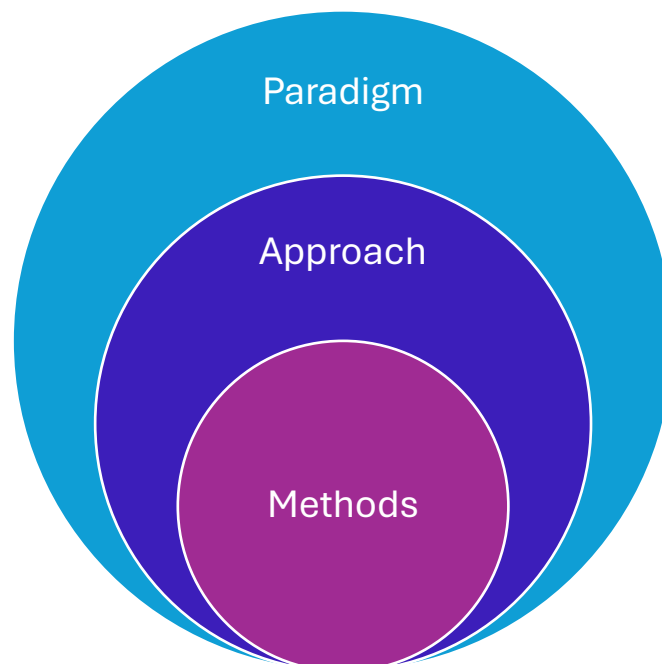
The next chapter discusses methodological considerations for how best to address these research questions.

Chapter 4: Methodological Issues

4.1 Methodological Definitions

The terms ‘method’, ‘methodology’, and ‘approach’ appear to be used interchangeably across textbooks, journal papers, and reports (McAllister & Lyons, 2019), which can cause confusion in interpreting the specific methodological theories and steps undertaken in a research project. Before delving into this chapter, the following terms inspired by McAllister and Lyons (2019) will be defined and consistently used throughout this paper to avoid confusion. Firstly, a ‘paradigm’ is a set of beliefs and values that informs the guiding principles of a research project. For example, qualitative research and quantitative research are two separate research paradigms as they represent different and distinct values (Bryman, 2008). Secondly, the ‘approach’, often also referred to as methodology, describes the system used to explore a particular research interest. The approach encompasses its own philosophical underpinnings and directs researchers toward specific data collection and analysis techniques. These specific techniques are referred to as ‘methods’ and should accurately describe how data were generated and interpreted.

Figure 4.1 *Methodological Terms Used in This Study, (McAllister & Lyons, 2019)*



4.2 Choosing the Paradigm

This study is situated within a qualitative research paradigm. Bryman (2008) discusses longstanding debates between researchers' rationale for whether quantitative or qualitative research is superior, however it is generally understood that there is no 'best' methodology, and methodological choices should be guided by the nature of the research question. While quantitative research may have been more suitable for addressing questions focused on measuring outcomes, frequencies, or effectiveness of particular interventions or service designs, this study aims to explore children's subjective experiences and perspectives, including challenges encountered, enjoyable aspects, motivators, or ideas for improvement. Qualitative research is more suitable for answering these broader and exploratory questions (Hersh et al., 2022; McAllister & Lyons, 2019), and is well suited to generating rich, in-depth insights into children's experiences and perspectives, which aligns with the exploratory aims of this study (Lyons et al., 2022).

4.3 Choosing the Approach

To address the two research questions, this study was designed as two separate but complementary qualitative components. The first component aimed to explore children's views of speech and language therapy service delivery and was completed using a qualitative evidence synthesis (Grant & Booth, 2009). Chapter 5 outlines the methods used and Chapter 6 presents the results, alongside a brief discussion of the patterns and trends found when analysing the data. The second component focused on children's views of home practice and was investigated through a qualitative interview study (Bradbury-Jones et al., 2017). Chapter 7 summarises the methods used and Chapter 8 presents the findings as well as reflexive considerations regarding the research process, such as children's responses to different methods and the influence of researcher positionality. Although the two components were analysed separately, they were interpreted together using a narrative approach. The rationale for choosing these approaches is described in more detail below.

4.3.1 Rationale for a Qualitative Evidence Synthesis

A secondary analysis of existing research was chosen to explore children's views of service delivery due to the numerous aspects of service delivery such as therapy structures, intensity, settings, and relationships. Conducting primary research to explore each of these aspects in detail would have been both time-intensive and potentially burdensome for child participants. Next, the type of literature review design had to be decided, for example a scoping review, systematic review, rapid review, or meta-analysis (Grant & Booth, 2009). A systematic review, specifically a qualitative evidence synthesis, was chosen as the study design for a number of reasons, outlined below.

Firstly, due to the subjective and exploratory nature of the research question, it was expected that most potential included articles would use a qualitative research design. Systematic reviews in healthcare research have predominately investigated the effectiveness of interventions (Cherry et al., 2017). Recently however, there has been increased importance placed on conducting different types of reviews. Qualitative syntheses are beneficial as they move beyond the question "does intervention work?" and instead investigates stakeholder views, barriers and facilitators of accessing intervention (Lavis, 2009). A qualitative evidence synthesis is suitable for attaining and summarising these study types, whereas an approach such as meta-analysis is more suitable for combining quantitative results (Grant & Booth, 2009).

Another component to consider when choosing a literature review design is whether a critical appraisal of included studies is appropriate and necessary. Scoping and rapid reviews for example do not usually require a critical appraisal, whereas appraisal is a requirement for systematic reviews (Dickson et al., 2024). Critical appraisal can identify risk of bias and limitations of the studies found (Shaheen et al., 2023), and allows the author to clearly state their confidence if their results are reliable and representative (Greenhalgh & Brown, 2024). Transparency of study quality is therefore useful for readers of systematic reviews when considering the significance of the results. Critical appraisal is also useful in identifying gaps in the literature, as identifying research areas that only have low quality evidence can

indicate that further exploration is necessary (Munn et al., 2018). Additionally, research involving children has been evolving from adult-directed to using more participatory methods (Gallacher & Gallagher, 2008). Examining and reporting common limitations of studies over time may also provide recommendations for improvement and inform future research (Munn et al., 2018).

4.3.2 Rationale for a Qualitative Interview Study

Home practice is a more niche and specific topic, which would be suitable for further exploration with participants, therefore a primary qualitative research design was chosen. While there are many established approaches with clearly defined guidelines, qualitative research can be varied and will not always neatly follow a particular approach (Bradbury-Jones et al., 2017). For example, Creswell et al. (2013) categorise qualitative research into five approaches, namely phenomenology, case study, narrative research, grounded theory, and ethnography. However Bradbury-Jones et al. (2017) found that a high quantity of published qualitative research only ‘borrows’ or combines components of these approaches, and are defined as ‘generic qualitative research’. The authors also argue that this approach can be beneficial and effective when it is correctly aligned with the study focus and data collection and analysis methods (see figure 4.2). A generic qualitative approach was adopted for the interview study, as the aim was to provide a clear, descriptive account of children’s experiences of home practice rather than to develop a theory, interpret a cultural group, or elicit narratives. A generic approach was also chosen over a similar phenomenological approach due to its more accessible nature, being less time intensive and requiring less budgetary support (Caelli et al., 2003). Caelli et al. (2003) also specify guidelines to ensure generic qualitative research studies are as transparent and rigorous as other more established approaches, such as stating the theoretical positioning of the researcher, the congruence between approach and methods, and the strategies used to establish rigour, all of which are discussed further in Chapter 7.

Figure 4.2 Qualitative Research Level of Alignment Wheel (taken from Bradbury-Jones et al., 2017)



4.3.3 Integrating Findings

This study uses a multi-phased qualitative design. The two qualitative studies were conducted concurrently, with neither phase informing the design of the other, but both addressing related aspects of the overall research aims. Data from each study was analysed separately, and integration occurred at the interpretation stage

by bringing together insights from both components. The integrated interpretations were discussed in Chapter 9, by organising the results into common key findings and reflecting on similarities and differences across the two studies. Bringing together perspectives from both studies enabled the researcher to capture views from a wider range of children and strengthened the depth and contextual understanding of the project.

4.4 Research Dissemination

Sharing findings is an important step in reducing the gap between research and practice (Minogue et al., 2022). Disseminating results in accessible formats also aligns with children's right to be informed about matters that affect them and supports more transparent and participatory research processes (Egli et al. 2019, Lundy et al., 2007). To facilitate dissemination, the completed thesis will be made publicly available through the university repository, and a manuscript is in preparation for submission to a peer-reviewed journal. In addition, an accessible child-friendly summary was developed and shared with participants and their families, and made publicly available via YouTube to promote wider accessibility and knowledge translation (see Appendix 15).

4.5 Researcher Positionality Statement

Qualitative research, by its nature, recognises the influence of the researcher on the process. While it is not appropriate to attempt to remove that influence, it is important to understand the positionality of the researcher (Groundar, 2025) and how that shapes the work.

I am a female speech and language therapist, early in my career. What I expected the profession to be was different from how I feel now. When I began my undergraduate degree, I imagined qualifying to work in a hospital setting alongside other "important" medical professionals. I saw the profession as one centred around treating a difficulty or improving a person's health, before they go on their

way. However over time, these somewhat superior and medicalised views were challenged. Firstly, I realised that I did not enjoy working in medical environments. Instead, I found myself drawn to working with children, their curiosity, unpredictability, and honesty bringing a different kind of meaning and joy to the work. I also began to notice times that children really surprised me, for example when one of my minimally speaking autistic clients excitedly grabbed my hand and started singing a song I always sang to him when he went on the swing, so clearly telling me “Jane, hang up the swing quickly I want to go on it!”. Gradually, I felt less like a “fixer” and more like a detective looking for strengths and motivators, valuing the connection and fun in my sessions a lot more than the preplanned session goals I had made myself, and often seeing better outcomes that way.

My specific interest in home practice began when I was working my first job as a research assistant. I was centrally involved in a large-scale funded research project collecting and analysing data on the experiences of families and therapists in Ireland engaged in speech and language therapy. Utilising a design thinking methodology, this study explored current challenges and opportunities within service delivery to help imagine and develop a useful “product”. In this role, I heard many parents describe feeling “lonely,” “confused,” “frustrated,” and “guilty” in supporting their child’s communication at home. At the same time, I heard SLTs speak about how much they cared about their clients and how strongly they wanted to help, yet also about feeling overwhelmed, constrained, and burnt out within the systems in which they worked. Listening to both perspectives made it clear that systemic challenges shape home practice experiences, and that there may be a mismatch between the values clinicians hold and the lived realities of families. Initially, my interest in children’s perspectives was connected to the product development part of the project. However, throughout the master’s programme, my thinking once again shifted. Realising how children’s perspectives can reveal insights that would not have emerged through conversations with adults alone, and the current underrepresentation of their views in research and practice, my focus evolved from “finding a solution” to first ensuring that children’s experiences are meaningfully heard and understood.

My understanding of the profession continues to evolve, and as an early-career SLT, I recognise that my perspectives are still developing and will change as I gain more experience. Throughout this study, I aimed to remain aware of my assumptions through ongoing reflection, supervisory discussion, and being transparent about methods used throughout. I am also mindful of the inherent power imbalance between myself as an adult researcher and the child participants. Steps were taken to respect children's autonomy and assent (discussed more in chapter 7). While such imbalances cannot be fully removed, I aimed to create an environment where children felt comfortable sharing their views.

Overall, this reflexive stance guided my efforts to prioritise children's voices while remaining conscious of my own influence within the research process.

Section Two:

A Qualitative Evidence Synthesis of Children's Views of Speech and Language Therapy Service Delivery

Chapter 5: Systematic Review Method

5.1 Study Aim

This chapter outlines the methods used to conduct a systematic review, which aimed to address the following research question:

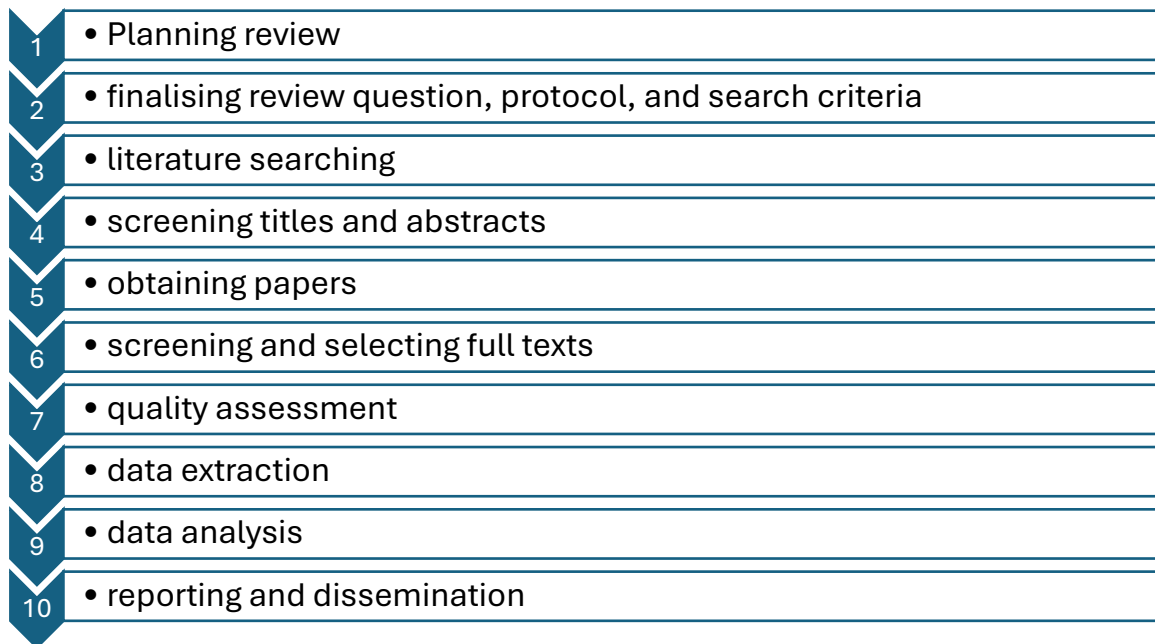
What are children's perspectives of speech and language therapy service delivery, including the positive and challenging aspects and ideas for improvement?

As described in Chapter 4, a qualitative evidence synthesis approach was chosen to understand and synthesise children's views on this topic, in order to establish what is already known, avoid duplicate studies, and identify current childhood research methods being used. This chapter details the review protocol, search strategy, eligibility criteria, screening process, quality appraisal, and methods of data extraction and analysis.

5.2 Systematic Review Protocol

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist was used to ensure all essential items were included when reporting this review (Page et al., 2021) (see appendix 1). Other guidelines were also consulted in the planning stage of the review such as the Cochrane Campbell Handbook for Qualitative Evidence Synthesis (Cochrane, 2025) and the JBI manual for evidence synthesis (Aromataris et al., 2024). A 10-step process was followed from initial planning to results write-up, summarised in figure 5.1.

Figure 5.1 10 steps to Completing a Systematic Review (Cherry et al., 2024)



5.3 Eligibility Criteria

A set of inclusion and exclusion criteria were developed to standardise the selection process of included studies, and ensure replicability of the screening method. The PICO method (population, intervention, comparison, outcomes) is often recommended in systematic reviews exploring the efficacy of interventions (Booth et al., 2024). However, qualitative studies generally do not aim to compare or test interventions, therefore an adapted PICo method was used (**P**opulation, phenomenon of **I**nterest, **C**ontext) (Booth et al., 2024), with the relevant inclusion and exclusion criteria detailed below under these headings.

5.3.1 Population

To be included in this review, the study must have included participants who: 1) were aged 3-18 years of age at time of participation, 2) have either received speech and language therapy services for any duration, or have SLCN but are still waiting for services. The age range was chosen due to the children being involved in more direct intervention than early intervention style approaches for infants and toddlers (Paul & Roth, 2011). Children above three are also more likely to recall experiences, in order to accurately express their opinions (Scarf et al., 2011).

Children who have experienced communication difficulty but have not yet received services were included as they may have insight into what type of support they would like, and could therefore contribute to the research question. Studies only consisting of adult participants were excluded as this review aims to understand children's first hand experiences, rather than interpretations of children's views by proxies such as parents or therapists. Studies that included multiple participant types (e.g., adults and children) were only included if results could be disaggregated.

5.3.2 Phenomenon of Interest

To be included in this review, studies had to explore the experiences, perceptions, and opinions of children with SLCN on aspects of speech and language therapy service delivery. These aspect include, but are not limited to:

- The structure and format of intervention: e.g., the length of sessions, intervention intensity, one-to-one versus group sessions etc.
- The setting and environment: e.g., preferences for school-based, clinic, or home-based sessions
- Mode of delivery: online therapy vs face to face
- Level of child and family involvement: for example, the impact of SLT-family relationship, involvement in goal setting, or the provision of home practice
- Experiences of intervention: other factors that contribute to positive or negative experiences of therapy.

Studies that investigate numerous topics were only included if results about speech and language therapy services could be disaggregated. Due to a minority of articles found during the screening process that were primarily about different topics (for example, experiences of cochlear implants or views on education) that contained minimal data points on speech and language therapy, a further exclusion criterion was developed: articles were excluded if the primary research aim is not focused on speech and language therapy. This criterion ensured that passing remarks in studies that did not intend to investigate intervention (for instance one child participant

mentions that they enjoyed speech and language therapy sessions when talking about their education experiences) did not dilute the stronger and more detailed evidence on the topic.

5.3.3 Context

This study aimed to summarise children's views of speech and language therapy services in general. Therefore studies examining perspectives across any service setting were included. In Ireland, services are commonly delivered through primary care, disability, education-based, hospital, mental health, and private settings (IASLT, n.d.), and equivalent services in other countries were also included. To maintain a focus on speech and language therapy, multidisciplinary studies were included only when the SLT's role could be clearly identified and analysed separately. Social validation studies were also excluded as this review focused more on children's real-life experiences of therapy rather than acceptability of new interventions under research conditions. Studies conducted in any country were eligible for inclusion; however, only studies published in English were included due to resource limitations associated with translation. This criterion is acknowledged as a potential limitation of the review.

5.3.4 Evidence Sources

For the purpose of this review, only published, peer-reviewed articles were included. Exclusion of grey literature may be considered a study limitation, as it increases the risk of publication bias and valuable research may be missed (Paez, 2017). However, as the research question is relatively narrow, and grey literature search can also be time and resource intensive (Paez, 2017), a detailed appraisal was prioritised over a wider breadth of sources. The chosen timeframe for study inclusion was January 2000 to 2025. This range was chosen to retrieve as many results as possible, and also allowed for comparison of the quantity, quality, and methodology used over time. Studies using any methodological approach could be

included, as long as they were primary research. Systematic reviews were incorporated to search reference lists, and then subsequently excluded.

5.4 Search Strategy

The JBI manual three-step searching process was used to develop a search strategy aligned with the research question and eligibility criteria (Lockwood et al., 2024). The first step is conducting exploratory initial searches. A subject librarian was consulted at this stage to identify key subject headings and synonyms, and to discuss the sensitivity and specificity of the initial search string. Initially the search was too sensitive, retrieving thousands of irrelevant studies due to the broad nature of most search terms (e.g., “child”, and “perspective”). To overcome this challenge, the subject librarian provided guidance on using the “near” Boolean operator for a number of databases so the terms “children” and “perspective” (or their synonyms) were within 3 words of each other.

The second step is to develop a comprehensive search string, tailored to each database being searched (Lockwood et al., 2024). Refining the research string is an iterative process to ensure the most accurate search results. The search strings for all databases included three “strands” that encompassed the population and phenomenon of interest: 1) children/young people, 2) opinions/views/perspectives, 3) speech and language therapy. Four relevant databases were chosen for a comprehensive search result, namely Medline, CINAHL Complete, Embase, and Web of Science. These databases provide access to a wide range of published studies across the health and social science fields (Dundar et al., 2024). PubMed was originally planned to be searched however following guidance from the subject librarian, Medline was chosen instead due to its superior accuracy when using the “near” Boolean operator. Searches took place on 3rd May 2025 and search results were exported to Covidence, an online data management tool (Covidence, 2025). Table 5.1 outlines the full search strings used for each database.

The third stage recommended by JBI is supplementary searching (Lockwood et al., 2024). As previously discussed, grey literature was not included in this review.

However citations were checked in relevant systematic reviews and articles from the second stage of screening.

Table 5.1 Search Strings for All Databases Searched

Database	Search string
Medline	((AB (child* OR teenager* OR adolescen* OR "young person" OR "young people") OR TI (child* OR teenager* OR adolescen* OR "young person" OR "young people")) N3 (AB (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*) OR TI (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*)) AND ((MH "Rehabilitation of Speech and Language Disorders+") OR (MH "Speech-Language Pathology") OR AB ("speech and language" OR "speech therap*" OR "language therap*" OR "speech patholog*" OR "language patholog*" OR "speech intervention*" OR "language intervention*") OR TI ("speech and language" OR "speech therap*" OR "language therap*" OR "speech patholog*" OR "language patholog*" OR "speech intervention*" OR "language intervention*"))
Web of Science	TS=((child* OR teenager* OR adolescen* OR "young person" OR "young people") NEAR/3 (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*)) AND TS=("speech and language" OR "speech therap*" OR "language therap*" OR "speech patholog*" OR "language patholog*" OR "language intervention*" OR "speech intervention*")
Embase	((child* OR teenager* OR adolescen* OR 'young person' OR 'young people') NEAR/3 (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*)):ab,ti AND ('speech and language rehabilitation'/exp OR 'speech-language':ab,ti OR 'speech therap*':ab,ti OR 'language therap*':ab,ti OR 'speech patholog*':ab,ti OR 'language patholog*':ab,ti OR 'language intervention*':ab,ti OR 'speech intervention*':ab,ti) AND [2000-2025]/py
CINAHL	((TI (child* OR teenager* OR adolescen* OR "young person" OR "young people") OR AB (child* OR teenager* OR adolescen* OR "young person" OR "young people")) N3 (TI (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*) OR AB (perspective* OR opinion* OR observation* OR experience* OR view* OR perception* OR interview*))) AND ((MH "Speech-Language Pathology") OR (MH "Rehabilitation, Speech and Language+") OR (TI ("speech and language" OR "speech therap*" OR "language therap*" OR "speech patholog*" OR "language patholog*" OR "language intervention*" OR "speech intervention*") OR AB ("speech and language" OR "speech therap*" OR "language therap*" OR "speech patholog*" OR "language patholog*" OR "language intervention*" OR "speech intervention*")))

5.5 Screening Process

To identify the studies which met the eligibility criteria from the search results, two phases of screening were carried out. The articles were first screened by their titles and abstracts by the researcher, using the inclusion and exclusion criteria outlined above. A selection of studies were also screened by the research supervisor to ensure that the eligibility criteria were clear and replicable. The research supervisor was blind to the first author's initial selection. There were no inconsistencies between the two reviewers. The second screen involved a full-text review using the same eligibility criteria, and was also carried out by the researcher. Due to resource constraints, it was not feasible for all full-text articles to be independently screened by a second reviewer. However, the final selection of included studies was discussed in detail with the supervisor to ensure that studies were consistent with the stated criteria.

5.6 Quality Assessment

The 'Critical Appraisal Skills Programme (CASP) Checklist: For Qualitative Research' was used to appraise the quality of the majority of the included studies (Critical Appraisal Skills Programme, 2024). This checklist is suitable for evaluating the quality of studies that use qualitative methodologies such as interviews, focus groups, and case studies. Only two of the included studies required an alternative tool as they used a mixed methods approach, and were therefore appraised using the Crowe Critical Appraisal Tool (CCAT), as it is appropriate to use with a multitude of research designs (Crowe et al., 2011).

5.7 Data Extraction

A data extraction table was developed by the researcher by compiling a list of important information required to answer the research questions (Fleeman & Dunder, 2024). The extraction table aimed to collect relevant information about the study characteristics, population, phenomenon of interest, and outcomes. The table was piloted during the extraction of the first two studies, and subsequent changes

were made to ensure all relevant data were collected, for example columns were added to record who collected the data, and if Public and Patient Involvement (PPI) was used (Fleeman & Dundar, 2024). An Excel spreadsheet was used to manage the data extraction. The following information was extracted from each study:

1. Bibliographic information: authors, year of publication, and title.
2. Study characteristics: country of data collection, data collection method, inclusion of PPI, who collected the data, and data analysis methods.
3. Participant information: number of participants, age range, child presentations, and type of service attended.
4. Results: aspects of service delivery reported on (e.g., telehealth, group therapy, home practice etc.), positives/benefits of the service, negative views of the service, and children's ideas for improvement.

5.8 Data Analysis

A thematic narrative synthesis approach was used to analyse the data extracted from the included studies. Narrative synthesis refers to the reporting of results in a descriptive manner, using words accompanied by data tables (Fleeman & Dundar, 2024). This approach was chosen as it aligns most with the purpose of the review; to identify the scope of what has been studied, assess the quality of evidence, and identify gaps in the literature (Lucas et al., 2007). Narrative synthesis involves three main stages (Popay et al., 2006):

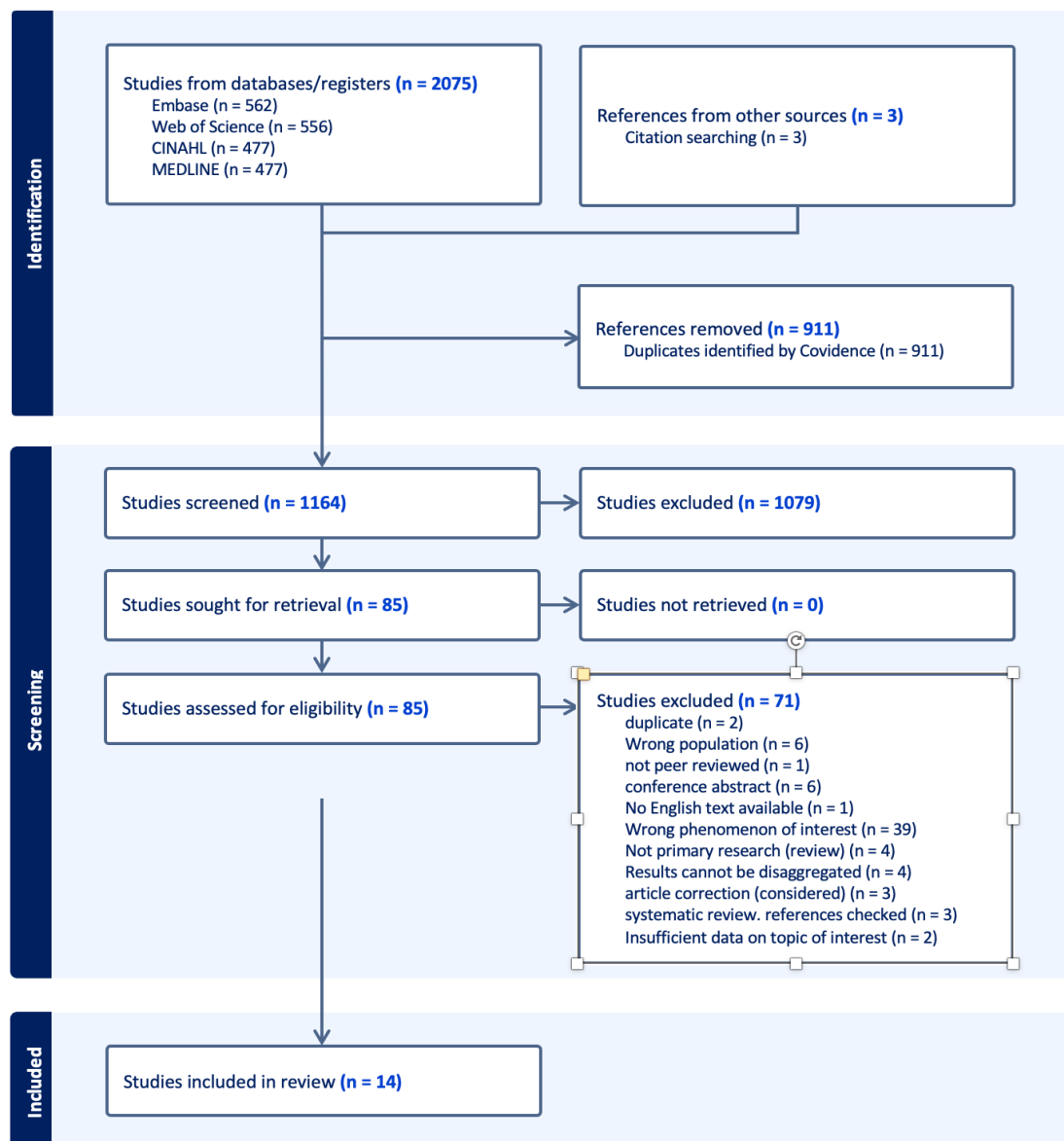
1. Developing a preliminary synthesis: this was completed through organisation of the data extraction table and familiarisation with the data. Extracted data from the table was analysed line by line and given a code, or topic heading, e.g. "rewards" "therapeutic relationships", "goal setting", "activities" etc. Patterns and trends across studies were noted.
2. Exploring relationships within and between studies: similarities and differences between study characteristics and results were documented and conflicting perspectives were noted.
3. Assessing the robustness of the synthesis: this was informed by the quality assessment process described above. The trustworthiness of the patterns found were reflected upon based on study quality and consistency.

Chapter 6: Systematic Review Results

6.1 Study Selection

Initial searches yielded 2075 search results. After duplicates were removed, 1164 studies progressed to title and abstract screening, where 1079 were then excluded. In the second stage of screening, 85 full texts were sought and assessed and a further 71 studies were excluded. Fourteen studies in total were included in this review. See figure 6.1 for an overview of the included and excluded studies.

Figure 6.1 PRISMA flowchart



6.2 Study Details

A summary of the study details has been provided in table 6.3, which also contains study identifiers, which are used occasionally throughout this chapter.

6.2.1 Quality Appraisal

Quality appraisal of all studies was completed, using either the Critical Appraisal Skills Programme (CASP) Checklist (CASP, 2024) or the Crowe Critical Appraisal Tool (CCAT) (Crowe et al., 2011), depending on the suitability of the tools in respect to the methods used (see table 6.1 and table 6.2). Although the CCAT and CASP tools are not intended to produce definitive quality ratings, their results were interpreted by the researcher. For this study, CASP scores of 8–10 were classified as high quality, 5–7 as adequate, and below 5 as low. CCAT scores of 80–100% were considered high, 60–80% adequate, and below 60% low quality. Studies were not excluded on the basis of quality appraisal, with methodological limitations instead taken into account when interpreting the strength and credibility of the review findings. All but one study (Clarke et al., 2001) had a rating of adequate quality or above. Quality indicators with lower scores related to ethical considerations such as discussion of consent and assent, unclear descriptions of data collection and analysis methods, and lack of discussion around researcher reflexivity and transparency of findings.

6.2.2 Study Methods

The majority of studies used a semi-structured interview design, with many using adaptive techniques such as visuals, drawing, or photo elicitation to ensure accessibility and increase children's engagement (studies 2, 3, 4, 5, 6, 7, 9, 10, 12, 14). Two studies used both semi-structured interviews and focus groups (11, 13). One study used video reflexive ethnography, showing participants videos of their goal-setting session to encourage reflection in subsequent semi-structured interviews (8). Two studies used a mixed methods approach, one using a mixed-method survey with both Likert and open box style questions (1), and the other

combining qualitative interviews with quantitative data on pre- and post- therapy standardised scores.

6.2.3 Service Characteristics

The included studies were conducted in a range of countries including the UK (3, 4, 10, 13, 14), Belgium (6, 9, 12), Australia (1, 11), Ireland (2, 5), the USA (7), and the Netherlands (8). The children discussed their experiences and ideas about various types of services, for example school-based services (4, 5, 8), self-employed/private SLT (6, 9), a preschool language unit (10), stuttering programmes (11, 14), community-based services (3, 8), a hospital voice clinic (7), and online therapy (1). The specific service children attended was unspecified or unclear in three studies (2, 12, 13).

6.2.4 Participant Characteristics

A total of 139 children who met this study's inclusion criteria participated across all included studies. Participants presented with a range of SLCN including speech sound disorders (SSDs) (1, 2, 3, 4, 10), a stutter (1, 4, 14), DLD (3, 5, 6, 8, 10), unspecified language difficulties (1, 2, 4), voice difficulties (7), cleft palate and/or lip (3, 9, 12), social skill difficulties (4), verbal dyspraxia (10), and AAC users (13). In some studies children presented with co-occurring conditions such as ADHD (1), autism spectrum disorder (1, 10), learning difficulties (3), or auditory processing difficulties (8). Other studies excluded children with multiple diagnoses. Participants ranged from three to 17 years of age. However, two children in Dematagoda and Sutherland's (2022) study did not report their age and Alighieri et al. (2024) only provided a median age, which was 12 years.

Table 6.1 *Quality of Studies Using the CASP Tool*



ID	Citation	Was there a clear statement of the aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participant been considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Overall impression
2	(Fourie et al., 2011)	Can't tell	yes	Can't tell	Can't tell	yes	yes	yes	yes	yes	yes	Adequate
3	(Merrick & Roulstone, 2011)	yes	yes	yes	yes	yes	Can't tell	Can't tell	yes	yes	yes	High
4	(Owen et al., 2004)	yes	yes	yes	Can't tell	yes	no	no	Can't tell	yes	yes	Adequate
5	(Gallagher et al., 2019)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	High
6	(Van Poucke et al., 2025)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	High
7	(Braden et al., 2018)	yes	yes	yes	Can't tell	yes	yes	Can't tell	yes	yes	yes	High

Table 6.3 Study Details

ID	Study	Data collection*	Data analysis*	who collected data?*	Participants	service type attended/discussed	Subthemes discussed
1	(Dematagoda & Sutherland, 2022) Australia	Mixed method survey	Thematic analysis of qualitative data and descriptive statistical analysis	N/A- survey completed at home. Participants specified if parents helped.	N=8 (5M, 2F, 1 unspecified) Age range: 7-15 years (2 children did not specify their age) Presentation: Mixed. Intervention goals: "speech", "language" "literacy", "fluency", or mixture. Some children had diagnoses of ASD, ADHD, "other".	teletherapy	◆ Mode of delivery ◆ Individualised activities
2	(Fourie et al., 2011) Ireland	Semi structured interviews, with arts and crafts, games, activity sheets	interpretive phenomenological analysis	2 final year speech and language therapy students (no relationship to participant)	N=6 (4M, 2F) Age range: 5-12 years Presentation: "Phonological delay" or "speech and language delay". No other medical or psychological conditions	Does not specify/mixed	◆ Setting clear expectations ◆ How to make goals ◆ What motivates me ◆ Importance of fun and games ◆ Therapeutic alliance
3	(Merrick & Roulstone, 2011) UK	Semi-structured interviews, with activities such as drawing, scrap-booking, and taking photos.	Grounded theory	University researcher (no relationship to participant)	N=11 (7M, 4F) Age range: 7-10 years Presentation: Mixed, including 4 with speech disorder, 1 with history of cleft palate, 2 with learning difficulties, 4 with specific language impairment	All recruited through a single speech-language pathology service in the southwest of England	◆ Setting clear expectations ◆ What motivates me

4	(Owen et al., 2004) UK	Semi-structured interviews, using objects and picture cards	“inductive process of analysis”	The child's own speech and language therapist	N=12 (11M, 1F) Age range: 6-11 years Presentation: described areas of communication difficulty including speech, receptive language, expressive language, social skills, and fluency	SLT provided in a school setting.	◆ Setting clear expectations ◆ What motivates me ◆ Mode of delivery ◆ Ideal setting ◆ Dosage and intensity ◆ Importance of fun and games
5	(Gallagher et al., 2019) Ireland	Semi-structured interviews with draw-and-tell and AAC techniques	Thematic analysis	PhD candidate and SLT, (no relationship to participant)	N=7 (5M, 2F) Age range: 10-13 years Presentation: 6 with DLD. 1 with DLD and emotional behaviour disorder	Children attended a range of services provided in Ireland (not described in detail).	◆ How to make goals ◆ What motivates me ◆ Ideal setting ◆ Importance of fun and games ◆ Individualised activities ◆ Peer support
6	(Van Poucke et al., 2025) Belgium	Semi-structured interviews	Descriptive thematic content analysis	Master's student in speech and language therapy. (no relationship to participant)	N=7 (4M, 3F) Age range: 7-10 years Presentation: DLD. Children with other diagnoses such as cognitive difficulties, ADHD, syndromes etc. were excluded	All children attended self-employed SLTs.	◆ What motivates me ◆ Timing of sessions ◆ Importance of fun and games ◆ Individualised activities ◆ Teacher support ◆ Peer support
7	(Braden et al., 2018) USA	Semi-structured interviews	Content analysis	Non-treating member of study team	N=35 (18M, 16F) Age range: 4-17 years Presentation: Voice difficulties including nodules, laryngeal edema, and polyp	All children attended voice therapy at the University of Wisconsin Voice and Swallowing Clinics at	◆ Setting clear expectations ◆ Timing of sessions ◆ Importance of fun and games ◆ Individualised activities ◆ Home practice ◆ Therapeutic alliance ◆ Family support

	American Family Children's Hospital.					
8	(Brauner et al., 2025) The Netherlands	Video-reflexive ethnography, using video footage of goal-setting conversations to facilitate semi-structured interviews	Reflective thematic analysis	Member of research team, (no relationship to participant)	N=2** (2M) Age range: CL1 was 7 years CL5 was between 4-11 years Presentation: CL1 had auditory processing difficulties and CL5 had DLD	Community practice and school-based service ◆ How to make goals
9	(Alighieri et al., 2023) Belgium	Semi-structured interviews, also using puppets, draw-write techniques, photo elicitation	Inductive thematic approach	Master's student in speech and language therapy. (no relationship to participant)	N=6 (3M, 3F) Age range: 5-12 years Presentation: non-syndromic cleft palate with or without a cleft lip.	Private community SLT ◆ Setting clear expectations ◆ What motivates me ◆ Ideal setting ◆ Timing of sessions ◆ Dosage and intensity ◆ Importance of fun and games ◆ Individualised activities ◆ Home practice ◆ Peer support
10	(Harvey & Spencer, 2019) UK	Semi-structured interviews, also using picture books with visual aids and drawing.	framework analysis	unclear	N=6 (3M, 3F) Age range: 3-4 years Presentation: All presented with "language disorder". 2 had additional diagnoses of SSD and developmental verbal dyspraxia. 1 being assessed for ASD	Preschool language unit (PLU) ◆ Ideal setting ◆ Peer support

11	(Hearne et al., 2008) Australia	Focus groups and semi-structured interviews	Analysis method not named. Description given: data transcribed, grouped into topics and broader topic headings	SLT with experience working with people who stutter, (no relationship to participant)	N=9 (9M) Age range: 13-17 years Presentation: stutter	2 attended individual therapy. 6 attended 1-week intensive programme (group). 1 attended Camperdown programme (unspecified).	◆ How to make goals ◆ What motivates me ◆ Mode of delivery ◆ Timing of sessions ◆ Dosage and intensity ◆ Home practice ◆ Peer support ◆ Family support
12	(Alighieri et al., 2024) Belgium	Semi-structured interviews	Inductive thematic approach	SLT and PhD . No participants treated by the researcher although some knew of her.	N=6 (3M, 3F) Age range: 6-13 years Presentation: Non-syndromic repaired cleft palate with or without a cleft lip.	All recruited through Ghent University Hospital. Unclear if this is where the children received therapy.	◆ Timing of sessions ◆ Individualised activities
13	(Clarke et al., 2001) UK	Interviews and focus groups. Also used visual methods	Unspecified. Describes organisation of data into themes and frequency counts of topics.	not specified	N=17 (genders not specified) Age range: No age range provided; median age = 12. Presentation: children who used a communication aid with at least 20 words/symbols. Children with degenerative condition or primarily social	Unspecified	◆ Mode of delivery

differences (e.g., ASD) were excluded					
14	(Caughter & Dunsmuir, 2017) UK	Semi-structured interviews	Thematic analysis As part of the thematic analysis, quantitative investigations were also undertaken, such as the calculation of the code frequencies across the data	The researcher was not involved in the children's intervention	N=7 (4M, 3F) Age range: 10-14 years Presentation: stutter
				Michael Palin centre for stammering	◆ Mode of delivery ◆ Ideal setting ◆ Therapeutic alliance ◆ Teacher support ◆ Peer support ◆ Family support

Legend: **M**=male, **F**=female. **ASD**=Autism Spectrum Disorder, **ADHD**=Attention Deficit Hyperactivity Disorder, **DLD**=Developmental Language Disorder, **SLT**=Speech and Language Therapist/Therapy, **AAC**=Augmentative Alternative Communication, **SSD**= Speech Sound Disorder

*some studies used multiple methods to answer different research questions. This table only mentions a research method if it was directly informed results relevant to this systematic review.

**This study reported 2 participants who fit the inclusion criteria of this review. However examples and illustrative quotes were only given from one participant.

Using a narrative synthesis method, relevant results from the included studies were identified, relationships within and between studies were examined. From this process, children and adolescents' perspectives were organised into four overarching themes, each reflecting a broad question they raised about speech and language therapy. (Table 6.4 provides a summary of these themes and illustrating quotes.)

6.3 Theme 1: Why do I Go to Speech and Language Therapy?

This theme captures children's perspectives on their expectations of intervention, their experiences of goal-setting processes, and factors that motivated them to attend speech and language therapy.

6.3.1 *Setting Clear Expectations*

Children began intervention with mixed insights into why they were attending therapy. For example, some children in Owen et al. (2004) and Alighieri et al.'s (2023) study understood the purpose of speech and language therapy, while others did not. Many participants in Braden et al.'s (2018) study explained reasons why they sought intervention such as vocal quality or impact on participation and quality of life, indicating that these children understood the general purpose of therapy. However, three children in the same study stated that they didn't know exactly what to expect from the intervention process (Braden et al., 2018). Children generally wanted to be told what they would be doing in the next session, and the rationale behind it (Alighieri et al., 2023; Owen et al., 2004). Similarly, predictable routines were valued by children as they preferred to know what to expect week by week (Fourie et al., 2011).

Intervention goals were not always clear to children, which led to confusion about what to expect. For example one child in a UK study described therapy as learning about "manners" (Merrick & Roulstone, 2011), and another child with an SSD expressed disappointment that they were not working on reading and writing

(Fourie et al., 2011). These discrepancies in expectation highlight the importance of clear, collaborative, and explicit goal setting.

6.3.2 How to Make Goals

A prominent topic reported in this review was children's desire for autonomy in the decision-making aspects of intervention. Firstly, there were mixed opinions from children with SSDs whether or not it was their choice to attend therapy (Fourie et al., 2011). Another child who stutters similarly talked about how they valued being able to decide if and when to seek support (Hearne et al., 2008). One study which aimed to explore different stakeholder opinions on goal setting in speech and language therapy shared the opinion of one seven-year-old. This participant described having difficulty following conversations between the SLT and parent about his goals and felt that he had to "secretly" look at the treatment plan (Brauner et al., 2025). He reported that being more involved in the conversation would have improved his experience. Children also wanted to choose how to work toward these goals, by being offered choices and supported to make their own decisions (Fourie et al., 2011; Gallagher et al., 2019).

6.3.3 What Motivates Me?

Children described a range of factors that motivated them to complete therapy activities, including both externally driven rewards and more internalised forms of motivation. External rewards such as sweets or stickers were mentioned by children with SSD and DLD as incentives for participation (Fourie et al., 2011; Van Poucke et al., 2025). Younger children with cleft palate also appreciated rewards, whereas older children in the same study did not receive rewards and also felt that it was unnecessary (Alighieri et al., 2023).

Beyond externally driven incentives, many children described motivations that appeared to reflect more internalised or autonomous reasons for engagement. Children frequently placed high value on learning new things, seeing improvement in their own skills, and gaining independence from their parents, which appeared to

motivate many to seek and continue intervention (Alighieri et al., 2023; Merrick & Roulstone, 2011; Owen et al., 2004). One adolescent who stutters was motivated by their career aspirations, explaining that improving their communication skills was important for future success (Hearne et al., 2008). Similarly, in a classroom-based intervention, children were motivated by the desire to contribute to classroom activities and to better understand and connect with their peers (Gallagher et al., 2019).

6.4 Theme 2: How Should Therapy Be Delivered?

Children across multiple studies discussed their perspectives on service design such as the mode of delivery, setting and environment, and intervention intensity.

6.4.1 Mode of Delivery

Four studies discussed children's views of individual versus group intervention. Children who stutter across two studies expressed a preference for group intervention (Caughter & Dunsmuir, 2017; Hearne et al., 2008). Participants explained that the peer support was beneficial for learning about how others dealt with similar difficulties, feeling less alone, and providing opportunity to ask each other questions. Children discussing group intervention in a school setting either had no preference, or also preferred group intervention (Owen et al., 2004). Some AAC users in Clarke et al.'s (2001) study were the only participants in this review who did not like the group aspect of their intervention, explaining that different working styles and less direct time with the SLT can make groups "boring".

Only one study investigated children's perspectives of teletherapy (Dematagoda & Sutherland, 2022). Although there was a small sample size and the study was not high quality, the results provided insights into both positive and negative aspects of this delivery mode. Children appreciated the novelty and convenience of accessing intervention via their computer. Some felt that it reduced the pressure of interacting with their clinician, and another felt that it helped

alleviate their fear of talking over the phone. Other children did not enjoy teletherapy as they felt that it was more difficult, they played less games than in-person sessions, there were technological problems, and some simply preferred the social element of seeing their therapist in person. Children suggested adding more games to improve the experience of teletherapy.

6.4.2 The Ideal Setting

The intervention setting was also raised by children with a range of presentations. Young children in a preschool language unit valued having outdoor space to play (Harvey & Spencer, 2019). School-aged children also discussing their ideal classroom setting, shared the importance of a safe and inclusive environment, emphasising the benefits of accepting differences and having no tolerance for bullying or teasing (Gallagher et al., 2019). The importance of a sense of safety was reflected by the children and teenagers who stutter as they stated that a relaxed and stress-free setting was important in enabling them to make progress (Caughter & Dunsmuir, 2017). Methods of creating a safe and relaxed environment were not examined in detail, however could be influenced by who is with the child during intervention. For example one child preferred not to bring their parents into the sessions with them (Alighieri et al., 2023), while another liked to bring in a friend for support (Owen et al., 2004).

6.4.3 Timing of Sessions

A common subject across six of the included studies was about fitting therapy into everyday life. In all six studies, it appeared challenging to find the right time to attend intervention. Many did not like being taken out of class or school in order to attend speech and language therapy (Alighieri et al., 2023; Van Poucke et al., 2025). At the same time, other children reported difficulty attending therapy after school due to challenges juggling other commitments and preferred activities like sports, jobs (Hearne et al., 2008), school homework (Van Poucke et al., 2025) and playing with friends (Braden et al., 2018). Another child reported feeling irritated about having to attend intervention during school break, also emphasising importance of balancing work with rest and relaxation (Alighieri et al., 2024).

Balancing life commitments and intervention, alongside the fatigue of travelling to appointments was even cited by children as reason they ended intervention (Alighieri et al., 2024), highlighting practical barriers faced by children and their families in attending therapy.

6.4.4 Intervention Intensity

Children in three studies mentioned their preferred intervention intensity, demonstrating varied perspectives. One child attending school-based intervention expressed that although they enjoy therapy, they do not want to go “too much”, suggesting a preference for lower intensity support (Owen et al., 2004). Children with cleft palate and/or lip had mixed opinions on session duration, with some feeling that 30 minute sessions were too long, some the right amount, and others preferring hour long sessions (Alighieri et al., 2023). Adolescents who stutter in Hearne’s study (Hearne et al., 2008) either attended a one week intensive group course or an individual programme with more spread out sessions. Those who attended the intensive model discussed it’s benefits such as not forgetting strategies between sessions (Hearne et al., 2008).

6.5 Theme 3: What Should Happen in Speech and Language Therapy?

This theme portrays children’s views on the key elements of speech and language intervention and their ideas about how it can be made engaging and enjoyable.

6.5.1 Importance of Fun and Games

In almost half of the included studies (studies 2, 4, 5, 6, 7, 9), children placed a strong emphasis on centring intervention around playing games and having fun. Children enjoyed intervention to varying degrees. Owen et al. (2004) reported that all participants unanimously enjoyed the therapy activities, however other studies also reported children who found the activities boring (Alighieri et al., 2023), dull (Fourie

et al., 2011), or described it as “work” (Merrick & Roulstone, 2011). Children with DLD in Van Poucke et al.’s (2025) study also had mixed views on if they enjoyed therapy. One child felt that therapy became less fun as they got older as games played reduced (Fourie et al., 2011). Games were mentioned as a positive aspect of intervention by children with voice disorders (Braden et al., 2018), DLD (Van Poucke et al., 2025), and other presentations (Fourie et al., 2011; Owen et al., 2004), particularly when those games were centred on the child’s individual interests (Braden et al., 2018).

Children also articulated ideas for how to make intervention more fun. For example, in their ideal classroom, one child suggested having enriching language learning opportunities beyond explicit language teaching, for example experiments in the classroom (Gallagher et al., 2019). One child wanted more variety in the games they played (Van Poucke et al., 2025) and children accessing teletherapy wanted better and more games for this online format (Dematagoda & Sutherland, 2022). Being offered choice was also important in making therapy fun (Fourie et al., 2011; Gallagher et al., 2019).

6.5.2 Individualised Activities

Across studies, children consistently valued the personalisation of therapy activities to reflect their individual interests and preferences. Firstly, the activities and games had to be age appropriate, as one child accessing teletherapy desired games that were “not for babies” (Dematagoda & Sutherland, 2022). The level of task challenge was also an important factor in how much children enjoyed or engaged with intervention. Many children felt that tasks needed to be appropriately challenging to support their engagement and learning (Alighieri et al., 2023; Alighieri et al., 2024; Gallagher et al., 2019). However, when activities were too difficult children reported not enjoying therapy, or being too afraid to try the exercises (Alighieri et al., 2023; Van Poucke et al., 2025), indicating a need for a happy medium. Children in voice therapy observed that the activities became easier over time as they became more familiar with what to do (Braden et al., 2018). Activities were also more engaging when personalised to the child’s preferences and

interests, for example, an adolescent who enjoyed incorporating singing into voice therapy (Braden et al., 2018).

6.5.3 Home Practice

Home practice was only briefly discussed in three studies (Alighieri et al., 2023; Braden et al., 2018; Hearne et al., 2008). Home practice was not explicitly defined in these studies, however child quotes most commonly referred to strategies and techniques they had to practice outside the clinic. There was an overall consensus among children that home practice was difficult and widely disliked. Alighieri et al. (2023) reported that all children in their study expressed dislike for home practice, most stating that they simply want to do other things when they are at home. Children with voice disorders and children who stutter both expressed difficulty making home practice a habit, remembering to complete the activities, and making time to do it (Braden et al., 2018; Hearne et al., 2008). One child in Hearne et al.'s (2008) study explained that even when they had time they were simply not motivated to complete it. An additional point raised by these children who stutter was self-consciousness practising strategies in every-day situations, with one child stating that practising strategies was more anxiety inducing than the stutter itself (Hearne et al., 2008).

That being said, it appeared that many children understood the importance of generalising skills learnt in therapy sessions into real life situations. Children in both Hearne et al. (2008) and Braden et al.'s (2018) studies spoke about how trying to maintain progress achieved in intervention can be difficult, feel unusual, and cause frustration. Participants also gave suggestions on how to alleviate these difficulties such as integrating activities into routines such as car journeys, making practices short (Braden et al., 2018), spending more session time talking about how to maintain skills, and attending extra follow-up appointments after intervention finishes to keep progress on track (Hearne et al., 2008). Raising community awareness of stuttering amongst peers, school staff, family and the public was also suggested as a technique to help children practise their techniques in real life situations (Hearne et al., 2008).

6.6 Theme 4: Who Supports Me in Speech and Language Therapy?

Children found support from their community, including SLTs, family members, and peers, to be an important aspect of speech and language therapy service delivery.

6.6.1 Therapeutic Alliance

The relationship between the child and their SLT was reported by four studies as an important aspect of service delivery. Firstly, children appreciated the SLT's knowledge in their clinical area and ability to share that knowledge with them (Braden et al., 2018; Caughter & Dunsmuir, 2017). The clinician's personality was also important to children (Braden et al., 2018; Caughter & Dunsmuir, 2017). Building trust and respecting confidentiality was also flagged as an essential part of the intervention process. Some children explained that as they built a strong connection with the therapist, they felt that they could discuss anything with them (Braden et al., 2018; Caughter & Dunsmuir, 2017; Fourie et al., 2011), whereas when trust was broken it resulted in a dislike of the intervention (Fourie et al., 2011). In one case, a child who stutters described experiencing greater fluency when working with a familiar and trusted SLT and suggested that rotating clinicians could increase challenge and help generalise skills (Hearne et al., 2008). When asked to describe their ideal SLT, children in Fourie et al.'s (2011) study also mentioned physical attributes such as being pretty and having a smile. Power dynamics were also observed by children, who suggested that being given choices about games, rewards, and attendance could help contribute to a more equal relationship (Fourie et al., 2011).

6.6.2 Teacher Support

Teachers and school staff were the only other professionals mentioned by children in three studies as having a supportive role in their speech and language intervention. One child with DLD appreciated when their SLT collaborated with their teacher to form goals (Van Poucke et al., 2025). Teachers were also described as

helpful for remembering to practice vocal strategies (Braden et al., 2018). Finally, children in Caughter and Dunsmuir's (2017) study generally described teachers as playing an important role in shaping a positive intervention experience.

6.6.3 Family Support

Family support was mentioned by children in three studies as helpful for remembering and practising strategies outside the clinic room (Braden et al., 2018; Hearne et al., 2008). Children who stutter also spoke about how their parents' reaction to their stutter was important in the therapeutic process, particularly when working toward acceptance (Caughter & Dunsmuir, 2017).

6.6.4 Peer Support

More children discussed the influence of peers in intervention than family. Children with DLD explained that a desire for connection with peers and inclusion in class participation were motivators for learning more about language (Gallagher et al., 2019). When describing their ideal language service in school, these participants highlighted the importance of a safe and inclusive classroom, wanting to be accepted and to accept others for their differences (Gallagher et al., 2019). Children in a preschool language unit also placed value on friendships, both within the unit and through integration with the mainstream class (Harvey & Spencer, 2019). As previously discussed, children and adolescents also value the peer support provided by group-based intervention (Caughter & Dunsmuir, 2017; Hearne et al., 2008). Contrastingly, children who attended individual private or community therapy did not confide in their peers as much. For example, children in two studies reported choosing not to tell their peers that they attended speech and language therapy. One child described feeling embarrassed (Van Poucke et al., 2025), while another felt there was no need to disclose this information, noting that everyone has different strengths and difficulties (Alighieri et al., 2023).

Table 6.4 Summary of Themes from Included Studies

Theme	Subtheme	Finding	Illustrating quote	Studies mentioning subtheme
Why do I go to SLT?	Setting clear expectations	Not all children knew why they were attended SLT	"I don't know why we do those exercises" (9)	4, 9
		Children liked to know what to expect and valued routines	"I need to know what we are going to do and why we are going to do it" (9)	2, 4, 7, 9
		Intervention goals were unclear	"I thought she was not very good for learning me things, I wanted to do spelling and reading and more things for a second class boy" (2)	2, 3
	How to make goals	Children want to make their own decisions, while supported by adults, about their intervention	"I want to pick books myself to read...help to choose a good book for me, not just what's the reader, at school, we just do the readers" (5)	2, 5, 11
		Children value being included in the goal-setting conversation	CI01 watched himself on the video and concluded that he would feel 'a bit happier' if he could have participated more in the goal talk because in the video he was 'looking a bit glum' (8)	8
How should therapy be delivered?	What motivates me?	Extrinsic motivators include rewards and playing games	"I'm a good girl and always get a sweet" (6)	2, 6, 9
		Intrinsic motivators include enjoying learning new things, seeing improvement, career aspirations, connection with peers, and being included	"I practiced so much that some day I got better" (3)	3, 4, 5, 9, 11
	Mode of delivery	Most children preferred group intervention, although not all	"It was a good thing for me to see how others dealt with their problems" (11)	4, 11, 13, 14
		Children discussed positives and negatives of teletherapy	"I like computers it's different" (1) "I didn't get to play online at all" (1)	1
	Ideal setting	Outdoor space is important for preschoolers in language unit	"play bikes and cars" (10)	10

	Children and teenagers want a relaxed and safe place to carry out intervention	"The Centre is a pretty stress-free environment" (14)	5, 14
	Children have different preferences about who they bring into sessions with them	"I prefer to be alone... they [parents] would be looking at me the whole time. No, no" (9)	4, 9
Timing of sessions	Many children did not like being taken out of class	"Mondays are hockey for us so I can't play hockey all year because I have to go to the speech-language therapist." (6)	6, 9
	It is difficult to fit therapy into busy life and other commitments while keeping rest/relaxation time	"I felt irritable. I was not very happy or very sad but I just did not like it when I received therapy during the break" (12) "Hard hard hard. Because we were so busy." (7)	6, 7, 9, 11, 12
Dosage and intensity	Children have varying ideas of the ideal frequency of therapy sessions	"Speech and language therapy lasts long. But when it [the session] is over, I think 'Wow, that went by quickly.'" (9)	4, 9
	Children who stutter liked the intensive week model	"I think the once every fortnight was like bad, cause you learn the techniques but the next week you forget them, because it isn't like going on and on, but this five day program was helpful cause you just kept on going every day and then you start to get it in your head" (11)	11
What should happen in SLT?	Children enjoyed intervention to varying degrees	"as you get older they do kind a like step it up, like it's a bit more dull as you get older" (2)	2, 4, 6, 9
	Games are important	"You get to learn and play games." (7)	2, 4, 6, 7
	Children want more variety of games and better games for teletherapy	"better games to play that aren't for babies" (1)	1, 6
	Children want to choose the games	"Researcher: How did she know you'd like that? Richard: Emm. I choose." (2)	2, 5
Individualised activities	Tasks have to be the appropriate age and difficulty level	"When the exercises are too easy, it is also boring. Or I have difficulties to focus." (12)	1, 5, 6, 9, 12

Home practice	Activities related to the child's interests are more engaging	"I liked it because she worked on songs that I was working on, with me." (7)	7
	Home practice is widely disliked by children	"I don't like it (laughs). I want to do other things at home." (9)	7, 9, 11
	Difficulties of home practice include remembering, finding time, wanting to do preferred activities instead, feeling self-conscious about practising strategies	"sometimes I didn't have enough time but other times I'd have time I just couldn't be bothered and do nothing and forget about everything" (11)	7, 9, 11
	Children find it frustrating trying to maintain new skills in real life situations	"I think the hardest part is to maintain it, I think" (11)	7, 11
	Suggestions for improvement include integrating practice into daily routines, spending more time with SLT discussing maintenance strategies, more follow-ups, and raising awareness of community	"It was easy to just do the warm ups because they were quick, and because the exercises were fast. So, even if you had like 5 minutes in the car, you could do some." (7) "I could do it on bike rides and stuff." (7)	7, 11
Who supports me in SLT?	Therapeutic alliance	Children value therapist's knowledge and personality Trust and confidentiality are important	7, 14
		"she's nice. She doesn't get angry" (7) "they know a lot more about stuttering than what we did before we came on the course" (14)	
		"(the therapists) are all really nice people so you didn't feel embarrassed to say anything, so you could say what you wanted to say even though if it might be a bit personal" (14)	2, 7, 14
	Younger children mentioned SLT's physical traits	"be pretty... wear make-up... a smile is very important"	2
	Children value being offered choices to reduce unequal power dynamics	"Researcher: How did she know you'd like that? Richard: Emm. I choose." (2)	2
Teacher support	Children appreciate when teachers are supportive, collaborate with the SLT to make goals, and help them remember strategies	"Sometimes she [SLT] calls the teacher and asks 'yeah what is he having problems with?' and then we will practise that a bit." (6)	6, 7, 14

Peer support	Connection with peers, acceptance, and inclusion motivate children with DLD	"so all these students are very different... there is all sorts in there... all with different talents" "strange is good in this school" (5)	5, 10
	Children in group intervention value peer support	"Let's say I was to do a presentation next week, but I had the course the day before, I can get some advice from my friends here [at the group intervention]" (14)	11, 14
	Children in individual therapy often don't share their difficulties or intervention experiences with their peers	"because I'm embarrassed"	6, 9

DLD= Developmental Language Disorder, **SLT=** speech and language therapist/speech and language therapy

6.7 Critical Reflections of the Evidence Base

To conclude this chapter, the following section presents critical reflections on the insights arising from these findings, including trends over time, study limitations, and the methodological approaches used.

Firstly, findings revealed that the overall number of publications on children's views of service delivery is limited, although there has been a noticeable increase in recent years. While a small number of studies were published in the early part of the 25 year period examined (e.g., Clarke et al., 2001; Owen et al., 2004; Hearne et al. 2008), most of the included studies were published within the last decade, suggesting growing recognition of the importance of including children's perspectives in research. Study quality also appears to be improving according to the appraisal measures, although more attention is needed on reporting how assent was obtained, describing the methods used, and discussing researcher reflexivity. This positive shift may partly reflect increased attention to children's participation rights within international policy and guidance (Lundy, 2007; Department of Children and Youth Affairs, 2015). Nevertheless, when compared with the larger body of literature exploring parent and clinician perspectives (e.g., Carroll, 2010; Doherty et al., 2025; O'Toole et al., 2021), children's voices remain underrepresented.

Furthermore, there were less children included in this review who had more significant disabilities or who were nonspeaking compared to those with SSDs, primary language difficulties, or a stutter. This disparity is likely due to traditional research approaches like interviews and surveys not being appropriate for children with more complex communication needs. More adaptation is required to include these children, reflecting a wider issue that children with disabilities are often excluded from activities typically developing children can be involved in (Njelesani et al., 2022). Further research exploring their views would be beneficial to ensure a more balanced view of children's perspectives.

It is also noteworthy that all included studies were conducted in high-income, Western countries. Limitations of this systematic review such as the search strategy being limited to English language may have skewed this data. Alternatively,

the disparity could be caused by inequities in research funding, publication access, and the dominance of English-language journals (Adam et al., 2023).

Communication, family roles, and concepts of disability differ widely across cultures, and it cannot be assumed that children in non-Western contexts would share the same expectations of service delivery (Hunleth et al., 2022). Expanding research to include culturally and linguistically diverse contexts would strengthen the current evidence base.

Finally, as expected given the focus on children's perspectives, the majority of included studies adopted qualitative methods, most commonly interviews. It is positive to note the different inclusive measures used in many studies such as visuals and photos, although not all studies reported on additional strategies used to support children with SCLN. There was also an absence of reported PPI across the included studies, as none explicitly described involving children research method design or in the dissemination of findings. This mirrors patterns observed in research with children in other fields, where disabled and non-speaking children are particularly likely to be excluded from participatory processes (Bailey et al., 2015). Egli et al. (2019) emphasise that dissemination to children is important to respect their right to know be informed on topics that affect them, counter power imbalance, support child-centred research, empower children to develop health literacy, and improve relationships between researchers and communities. Further research including PPI would be beneficial.

6.8 Chapter 6 Summary

Children of different ages and with a range of communication profiles shared varied perspectives on the positive and negative aspects of speech and language therapy service delivery. Although individual experiences differed, several common themes were identified, regarding aspects of intervention that children considered important. For example, children expressed clear views about the setting, environment, timing, and intensity of intervention. They emphasised the importance of being involved in discussions about expectations and goal setting, highlighting the

value of autonomy and accessible communication when making decisions about therapy. Children also described the importance of fun and engaging activities that were tailored to their needs and preferences. Experiences of intervention were often shaped by the support of a wider network, including speech and language therapists, educators, family members, and peers.

This review demonstrates that qualitative methods can successfully support children to share their perspectives. However, the identification of only 14 studies published over the past 25 years highlights the limited attention given to children's perspectives and indicates a need for further research that reflects the diversity of children with SLCN. Improvements in study quality are also needed, particularly in relation to ensuring that children's views are gathered through appropriate consent and assent processes. The broad nature of most of the included studies also highlights the need for further research on more specific aspects of service delivery such as home practice, which forms the focus of the interview study presented in the following section.

Section Three:
Child Interview Study

Chapter 7: Interview Study Method

7.1 Introduction and Study Aim

This chapter presents the qualitative interview study with children with SLCN, which aimed to address the second research aim:

What are children's views of speech and language therapy home practice, including barriers and facilitators of engagement, and ideas for improvement?

As outlined in Chapter 4, the study was situated within a qualitative research paradigm, to gain deeper insight into children's therapy experiences (Lyons & McAllister, 2018). A generic qualitative approach was adopted to allow flexibility in data collection and analysis while remaining transparent and methodologically coherent (Bradbury-Jones, 2017). Caelli et al. (2003) note that the credibility of generic qualitative research depends on clearly stating the researchers' theoretical positioning and strategies used to ensure trustworthiness. This chapter therefore outlines how principles of the Mosaic approach were incorporated into the study design, which is an approach that aligns with the child-centred positioning of the researcher (see researcher positionality statement in section 4.4). The chapter also describes the recruitment, data collection and analysis procedures, alongside considerations for maintaining ethical practice and supporting children's autonomy and informed participation.

7.2 Mosaic Approach

While this study is defined as a generic qualitative approach, the Mosaic approach was drawn upon as a theoretical basis (Clark, 2017). The Mosaic approach was developed by Alison Clark as an inclusive and participatory way to involve young children in the research process. The approach provides a "Framework for Listening" to children, guided by the following six key principles (Clark, 2017):

1. **Multi-method:** Drawing on the belief that children have “different voices” with which they communicate, the Mosaic approach emphasises that multiple methods should be used to listen to children’s expression beyond their spoken words. Using creative and visual tools, along with observing non-verbal communication can help provide children with opportunities to express themselves in whatever way they feel most comfortable and encourage reflection. Further discussion on what tools were used in this study can be found in section 7.8.
2. **Participatory process:** Research should aim to position children as active participants in the research process. This principle is founded on the perception of children as capable communicators and contributors, which aligns with principles of PPI. Although PPI was not used in this study due to recruitment difficulties, children were active participators in the interviews themselves, by allowing them to guide the discussion, chose their own methods to communicate etc.
3. **Reflexive:** The Mosaic approach requires adults to reflect on their own assumptions and power dynamics, and to check their interpretations with children to ensure that the final understanding reflects children’s perspectives rather than their own adult views. Reflexivity in this study was completed by the researcher reflecting on their positionality, completing reflexive logs after each interview, clarifying answers, and clearly instructing children to correct the interviewer if they interpret something incorrectly.
4. **Adaptable:** Techniques used to listen to children are not set in stone, rather the researcher should reflect on which methods are most appropriate for the specific participant involved. In this study for example, materials based on one participant’s interest in the “Dog Man” book series were created to encourage participation in an interview.
5. **Focus on children’s lived experiences:** The research should focus on children’s everyday experiences rather than viewing the child as a ‘consumer’ of a service. Rather than focusing only on their opinions of speech and language therapy service, the interviews encouraged children

to discuss how therapy-related activities fit into their lives, how they felt about practising skills outside the clinic, and what helped or hindered their engagement.

6. **Embedded into practice:** Listening to children should be embedded within everyday practice rather than treated as a separate or one-off activity. This research has influenced practice of the researcher, but through dissemination of the research will hopefully inform and educate other clinicians.

Following these principles requires researchers to view children as experts of their own lives and believe that children are skilful communicators once provided with adaptive methods to support their unique communication styles (Clark, 2017). These beliefs align with the researcher's positioning, as through developing research and clinical experience it is evident that following a child's lead can often lead to improved enjoyment and engagement in therapy, and engagement is essential for successful home practice (see more in section 4.4).

7.3 Ensuring Rigour

Qualitative research has often been described as “soft and unscientific”. However, researchers in the qualitative paradigm argue that it is differently rigorous rather than less rigorous than quantitative research (McAllister & Lyons, 2019, p. 267). Several strategies were used to ensure the research was rigorous. Thorough description of the theoretical positioning, approach, data collection and analysis methods, and limitations of the study provide transparency and replicability. Triangulation of data collected from children with information provided by parents provides credibility as the data is observed from multiple perspectives (McAllister & Lyons, 2019). Lastly, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to accurately report the process and findings (Appendix 2).

7.4 Ethical Considerations and Consent

This research was approved by the Research Ethics Committee of the School of Linguistic, Speech and Communication Sciences, Trinity College Dublin (Appendix 3). Trinity College guidelines were followed, along with other ethical considerations presented by previous scholars who conducted research with children (e.g., Foster et al., 2023; Merrick, 2011).

In line with ethical principles and the Trinity Policy on Good Research Practice (Trinity College Dublin, 2024) written consent from the child's parent or guardian was required for a child to participate in the study (Appendix 4). The parents' consent also included giving permission to use their own contributions in the data collection and analysis process. Assent was also required from the child. All children in this study signed an assent form (Appendix 5), however the process of obtaining assent went beyond this form. "Assent" is a commonly used term to describe a child's agreement to participate when they may not fully understand all concepts of the study to the same extent as an adult. For example the research aims and data security measures may be difficult for a child to fully comprehend, whereas the voluntary nature and of the types of activities in which they will be involved can be better understood (Merrick, 2011). In terms of the process of obtaining assent, a child's capacity to understand and agree to research has been debated (Fargas-Malet et al., 2010). Researchers' philosophical viewpoint on how they view children in research has influenced this debate, as Fargas-Malet (2010) summarises the three schools of thought: 1) children are the same as adults and require the same methods used, 2) children are not like adults and can only participate as observed participants in ethnography, and 3) children are similar to adults but require different supports to match their individual competencies. In line with the Mosaic approach, values of the researcher, and Trinity College Dublin guidelines, the latter of these beliefs fit best with this research. However, precautions should be taken when asking children for their assent.

There are two major risks to address when obtaining assent from children with SLCN (Merrick, 2011). Firstly, children with SLCN are often underrepresented in

research, partly due to gatekeeping by parents who, understandably, may wish to protect their child from discussing topics that could be upsetting, such as sensitivities around their communication difficulties. (Merrick, 2011). To overcome this challenge, building rapport with the child's parents before beginning the study and being transparent about what the interview entails led to trust developing between the researcher and parent. Other gatekeepers may have their own views on who is 'capable' of participating (Lewis & Porter, 2004). To reduce the risk of excluding children with more severe communication difficulties, who likely have unique insights into the topic, all gatekeepers, including speech and language therapy services and parents, were informed of the inclusion criteria, the multi-method communication approach used in the interviews, and that the interview would be conducted by a qualified SLT. The second risk outlined by Merrick (2011) is that children are included in a study without their true agreement. This project followed the guidelines outlined by Lambert and Glacken (2011) in order to mitigate this risk, outlined in table 7.1.

Beyond issues of consent and assent, other ethical considerations included confidentiality and child protection. The researcher completed the Garda Vetting process through Trinity College Dublin and undertook "Children First" safeguarding training prior to data collection. Additionally, all data were stored in accordance with Trinity College Dublin guidelines, and the researcher completed GDPR training to ensure appropriate handling of sensitive information. To protect participants' identities, pseudonyms were also assigned to all children and parents when reporting of the results.

Table 7.1 *Steps Taken to Gain Assent (adapted from Lambert & Glacken, 2011)*

	Guidance	Steps taken in this project
A	Assess the child's capacity to assent and build rapport	• Conversation with the child's parent about their communication skills, personality, and interests allowed researcher to gain an understanding of the child's communication profile • Building rapport with the child through informal conversation before asking for assent developed the relationship and allowed the researcher to get to know the child's communication style.
S	Supply child with adequate and understandable information	• Written information about the study was provided to the child in an easy-read format (Appendix 9) • The researcher offered for the information leaflet to be adapted, a video version provided, or a meeting with the child to explain the research.
S	Search for signs of refusal and assure no pressure is applied	• Body language was considered, e.g. facial expression, turning away from the interviewer • Non-responses were taken into account • Explicitly assuring the child that their decision not to participate will not make the researcher upset and will be respected
E	Evaluate evidence of understanding of child through questions and feedback	• Opportunity to ask questions was offered • Comments and concerns about the process were addressed
N	Negotiate assent continuously	• Child was reminded that they could stop or take breaks at any time • During the interview the researcher observed for subtle signs of dissent such as changing the topic, not replying, and losing interest in the interview • The child was provided with a visual (figure 7.1) to provide an easier way to ask to take a break or stop
T	Time to think about decision	• Parent and child were given a minimum of one week to consider the information before giving consent/assent

7.5 Research Sample

Children aged 6-17 with experience of completing home practice, and their parents, were eligible for recruitment to the study. This age range was selected because younger children are more likely to receive parent-implemented intervention, while those aged 18 and over typically transition to adult services. Convenience and snowball sampling were used, meaning participants were recruited from those readily accessible to the researcher and were invited to share study information with others (Bryman, 2008). As participants were recruited based on accessibility and availability, there is a risk that the sample may not capture the full diversity of experiences relevant to the research question. For example, participants who were more willing or available to take part may have shared particular characteristics, such as higher engagement with home practice, which may have influenced the perspectives represented in the findings. However, this approach was chosen due to its accessibility in terms of cost and time efficacy. Limitations were acknowledged by clearly stating that the results offer an insight into some children's experiences rather than being representative. There was a target sample size of 6-15 child participants, following recommendations from the literature (Bradbury-Jones et al., 2017; Lyons & McAllister, 2019), however due to recruitment difficulties, 5 children participated.

Children were included in the study based on their involvement in speech and language therapy home practice rather than their specific communication needs or type of services accessed (see Table 7.2 for inclusion criteria). It was initially required that the child had received speech and language therapy intervention for a minimum of six weeks in the previous year to improve the likelihood of the child accurately and easily recalling their experiences. However following challenges recruiting participants, the time frame was increased to the previous 2 years. Participants must have been aware that they received home practice and have basic knowledge of what it entailed (e.g., games, worksheets, practising strategies). However, completion of home practice was not required, as the study also sought to capture the perspectives of children who chose not to

engage with the activities and their reasons for this. There were no inclusion or exclusion criteria for the parents other than being the child's legal guardian.

Table 7.2 *Inclusion and Exclusion Criteria for Interviews with Children*

Inclusion Criteria	Exclusion Criteria
Children between the ages of 6 and 17 (inclusive)	Children under the age of 6 and adults 18 and older
Attended a minimum of 6 weeks of speech and language therapy in the previous two years	Attended speech and language therapy more than two years ago, or had no experience with speech and language therapy
Child received home practice as part of their intervention. The child must have been aware of what the home practice entailed.	No home practice was received or home practice consisted solely of parent-implemented communication strategies or environmental changes.

7.6 Recruitment

Flyers containing brief details of the study were posted on social media which were advertised toward parents of children who have accessed speech and language therapy services (Appendix 6). Several speech and language therapy services known to the researcher and research supervisor were also contacted in request to act as a gatekeeper of the study (see Appendix 7 for Gatekeeper Letter). SLTs in these services disseminated the flyers to service users. As previously mentioned, the gatekeepers were informed of the multi-method interview approach and the inclusion criteria.

Parents who were interested in the study could then contact the researcher who issued participant information leaflets for parents (Appendix 8), and an accessible, easy-read version for children (Appendix 9). Parents were offered a phone call to explain the research and discuss how to make the information more

accessible to their child, if required. No parents requested further adaptations to the information leaflet or a video version when offered. Parents and children were given a minimum of one week to consider the information before the researcher contacted the parents again to answer remaining questions and arrange the next steps.

7.7 Data Collection Stages

Data collection occurred in either two or three steps, the final step being optional. The first stage involved collecting information from parents of children involved in the study via phone or video call using a note-taking template, developed by the researcher (Appendix 10). Parent information was required for several reasons. Firstly, the researcher could confirm the child's eligibility to participate in terms of age and experience with home practice. Secondly, the information provided could be used to make interview questions more tailored, as some children may initially find it difficult to recall specific details about their experience. Similarly, the third reason was to gather practical information about the child's communication preferences and mobility, such as whether they use AAC, benefit from visuals, are predominantly verbal communicators, their ability to point/gesture/write/draw, and to ensure the interview location was accessible. It is also argued that including parents can enhance the Mosaic approach as they provide additional insights and contexts that can help the researcher prompt and interpret the child's responses (Rogers & Boyd, 2020). Finally, the initial conversation helped establish rapport with the parent, which is an important step in addressing power dynamics between the researcher, parent, and child (Dubois et al., 2022).

Following initial information-gathering with the parent, the next stage was to conduct the interview with the child. As interview location can influence how children feel and what they share (Fargas-Malet et al., 2010), families were offered the choice of meeting at home, in the Speech and Language Department at Trinity College Dublin, or online depending on their comfort and preferences. Three interviews took place at Trinity College Dublin, one online, and one in the child's

home. The child's parent stayed beside the child or waited nearby during the interview. Time was spent at the beginning of the interview building rapport through informal conversation about the child's interests and playing games. Next, the researcher read through the participant information leaflet again with the child alongside simple guidelines to support their role as an equal participant, such as being allowed to correct the researcher if they misinterpreted something, ask for clarification, or say "I don't know" (Waterhouse et al., 2023). A traffic-light system was also introduced to allow children to indicate if they wished to continue, take a break, or stop (see figure 7.1). A topic guide developed by the researcher (Appendix 11) provided prompts about children's experiences of home practice, including what they enjoyed and what they would change. Typically, open ended questions are advised to encourage the participant to reflect and lead the conversation (Fargas-Malet et al., 2010). However, as some participants presented with expressive language difficulties, some closed and multiple choice questions were included to increase confidence and support communication. The interviewer also allowed the conversation to be led by the children if the topic diverted from the topic guide. All interviews were audio recorded and had a duration between 29-45 minutes.

The third optional stage was a second interview with the child. Although a second interview was initially planned, due to recruitment difficulties the strategy was changed to advertise for one interview only, as it was thought that the time commitment may have been hindering sign-up. A second interview with each child would have been beneficial for several reasons. Firstly, a follow-up meeting would allow additional time to build rapport and reduce power imbalances, which may enable children to share their perspectives more openly. Secondly, multiple interviews can support reflexivity for both the child and the researcher by refining questions and methods, clarifying earlier responses, or expand on discussions. Finally, dividing the discussion across two shorter interviews may help maintain attention and comfort. One participant participated in an initial online meeting, although due to clear signs of dissent, it was not recorded, transcribed, or counted as an interview. Instead, the researcher focused on introducing the study and engaging the child in conversation about his interests. The rapport developed during

this initial meeting encouraged the child to take part in a second, in-person interview. Information gathered about the child’s preferences and communication style was incorporated into the second interview, during which he was more willing to engage and provided assent to participate. The remaining four participants took part in one interview.

Figure 7.1 *Traffic Light System for Autonomy and Assent*

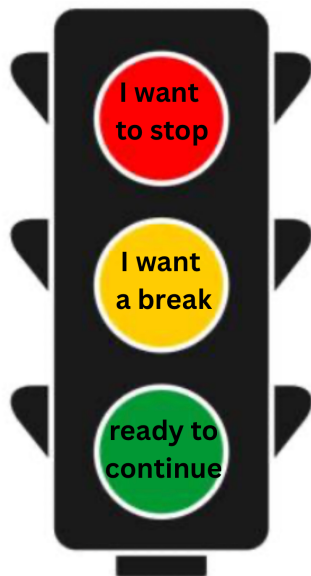
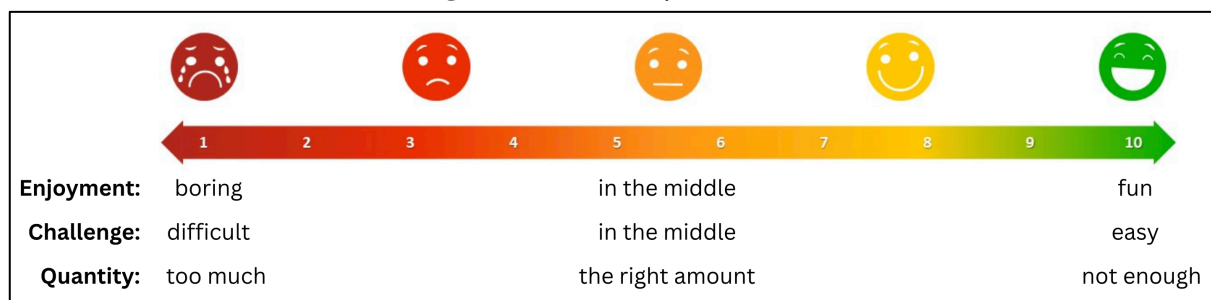


Figure 7.2 *Visual Rating Scale Used During Interviews (with examples of key words interviewer said and wrote during the discussion)*



7.8 Interview Tools

Multiple methods were used throughout the interview to support children’s expression, in line with the Mosaic approach. These tools are summarised in table 7.3, and will be referred to by name in the Chapter 8 when discussing the study findings.

Table 7.3 *Methods Used in Child Interviews*

Name	Explanation
Fictional Narrative (Appendix 12)	To support children’s understanding of therapy goals and prompt reflection, all participants were read a short fictional story about a child named Sarah who attended SLT. The story described why Sarah attended therapy, the activities she completed in sessions and at home, and her feelings about these experiences. It was then used as a reference point during the interview, with reflective questions such as, “Did you work on learning new words like Sarah, or did you learn something else?”
Semi-structured verbal questions (Appendix 11)	A topic guide was used to provide a general structure for the interview. Question wording was adapted depending on the child’s language skills and follow-up questions were guided by the child’s response.
Challenge Rating Scale (see figure 7.2)	A visual scale from 1-10 was shown and the following key words were written to orientate the participant: 1=very difficult, 5=in the middle, 10=very easy
Enjoyment Rating Scale (see figure 7.2)	A visual scale from 1-10 was shown and the following key words were written to orientate the participant: 1=very boring, 5=in the middle, 10=very fun
Quantity Rating Scale (see figure 7.2)	A visual scale from 1-10 was shown and the following key words were written to orientate the participant: 1=way too much, 5=the right amount, 10=not enough
Written Multiple Choice (casual)	When participants had difficulty providing verbal answers, the interviewer would sometimes write down multiple options. For example, for the question “what name should we give the work we do at home?” the options might be a) homework, b) home practice, c) activities, d) something else?
(Kahoot)	The interviewer developed a Kahoot quiz to increase engagement for one participant, with questions similar to the example above.
(Dog Man Booklet) (Appendix 13)	The interviewer also developed a multiple choice question booklet themed around the “Dogman” books, which was a prominent interest for two participants. The same type of questions as the example above were included.
Visual Sorting Exercise (Appendix 14)	The participants were shown visuals and had the option of sorting them into “like” and “dislike” categories.
Drawing	The participants had access to paper, pencils, and colouring pencils and could choose to draw if they wished.

Also considered a “tool” in data collection was the active reflection of the researcher throughout the process, as aligned with the Mosaic approach principles. Reflective logs were completed by the researcher following each interview to support ongoing reflexivity throughout the data collection process. These logs provided a space to consider the dynamics of each interaction, including how the researcher’s role, communication style, and assumptions may have influenced the conversation. This process helped to identify potential power imbalances between the researcher and child participants and informed small adjustments to the interview approach, such as changes to the interview introduction, questioning style, pacing, and the use of visual supports.

Figure 7.3 *Excerpt from Reflective Log*

I had my first interview with a participant today. He was very chatty and had great insight and ideas about SLT. At the end of the interview, Jack made a lovely comment about how he hoped his ideas could help other children enjoy speech and language therapy. This comment made me realise that although I briefly explained the research aims at the beginning, I did not fully explain why hearing his and other children’s perspectives is so important. I think this would be beneficial going forward so that they understand why they are meeting me and why it’s so important that adults listen to children’s views. This might also encourage the next participants to be honest about their experience and confident giving their ideas. Reflecting back on why I chose this research topic, I think better explaining the research may give them a sense of empowerment, especially if their views were not taken into account in the past.

7.9 Data Analysis

Thematic analysis was used to interpret the data collected (Braun & Clarke, 2021). There are six key phases in this method which will be discussed in detail below. All stages were completed by the interviewer/author only.

7.9.1 Phase One: Familiarisation with the Data

Familiarisation involves immersing yourself in the data to gain a thorough understanding of the dataset before beginning the more formal process (Braun & Clarke, 2006). The first step at familiarisation is transcribing interview recordings. There are no prescribed transcription conventions to complete thematic analysis, however, Braun and Clarke (2006) recommend a verbatim account of all participant utterances. Non-verbal communication such as laughing, gestures, and moving or pointing to visuals were also transcribed. At this stage, information provided by children was also cross referenced with information provided by parents, and discrepancies were noted. The researcher then re-read the transcripts, taking notes about initial thoughts and patterns emerging from the data. Transcribing and re-reading interviews is a time-consuming process, which can be off-putting when deciding data analysis methods. However, the immersive process was helpful in transitioning from data collection into an interpretive role (Braun & Clarke, 2006).

7.9.2 Phase Two: Generating Initial Codes

This stage of data analysis involved reading each transcript and identifying features that were relevant to the research question. The transcripts were copied to an Excel spreadsheet, where each sentence could be clearly identified in separate cells. Each sentence or group of sentences were then given a descriptive label or 'code'. Repetitions of similar points were given the same code, and new codes were generated while progressing through the transcripts. Data coding was an iterative process, so as new examples of repeated codes emerged, and reflection was carried out by the researcher, some changes were made to the names and meanings of the codes.

7.9.3 Phase Three: Generating Themes

Once a list of codes was finalised, it was necessary to once again take a step back from specific responses and look more broadly at how the codes were interlinked (Braun & Clarke, 2006). A table of codes, relevant quotes, and initial

ideas on how the codes were related was developed on a Word document to help the researcher visualise the data. Relationships between codes were identified and could be conjoined to form subthemes. The subthemes also had links and similarities and could be further grouped into overarching themes. A hand drawn mind map was also used to help the researcher organise and reflect on the related codes, subthemes, and themes. Braun and Clarke (2021) strongly emphasise that themes do not ‘emerge’ as suggested in some literature. Rather, theme generation is reliant on the active identification and interpretation carried out by the researcher in this and the following phases.

7.9.4 Phase Four: Reviewing the Themes

This phase involved returning to the original dataset to ensure that the themes identified in phase three accurately represented the children’s interview responses. Discrepancies were identified, and minor adjustments were made to the thematic mind map to better represent the patterns observed. This process involved revisiting individual transcripts, checking coherence of each theme, and making sure that illustrative quotes supported the overall interpretation. This phase highlights the iterative and reflexive nature of thematic analysis, which aligns well with the principles of the Mosaic approach (Clark, 2017).

7.9.5 Phase Five: Define and Refine

In this phase, the data extracts within each theme were re-examined to consider what they revealed and how they contributed to the overall patterns identified. This phase involved checking that the different accounts from children worked together in a meaningful way, so that each theme told a clear and coherent story (Braun & Clarke, 2006). Theme names were decided which attempted to catch the attention of the reader. An overview of themes and subthemes in a more refined mind map can be seen in figure 8.1.

7.9.6 Phase Six: Write Up

The final phase of thematic analysis involves producing a detailed written account that tells the ‘story’ of the dataset (Braun & Clarke, 2006). The themes identified in this study are presented in Chapter 8, supported by direct quotations from the children to illustrate the findings. These results are then interpreted alongside the findings of the systematic review in the discussion chapter (Chapter 9), allowing for an integrated discussion of children’s perspectives across both studies. This combined interpretation situates the interview findings within the wider literature and current speech and language therapy practice, providing a deeper understanding of the implications for research and practice (Chapter 10).

7.9 Chapter 7 Summary

This chapter outlined the qualitative interview study, which adopted a generic qualitative design informed by the theoretical and methodological principles of the Mosaic approach to explore children’s perspectives on speech and language therapy home practice. A combination of visual and verbal methods were used in interviews with children, supporting accessible and flexible communication in line with participants’ individual needs. The dataset was analysed using thematic analysis, allowing for a reflexive interpretation of the children’s accounts and the identification of key patterns across their experiences.

Chapter 8: Interview Study Results

8.1 Participants

Demographic information about the child participants was collected through parents via a phone call prior to the interview (see table 8.1). Five children (4 boys and 1 girl) participated in this study. Their presentations were varied and included Autism, speech sound disorder (SSD), dyslexia, and general receptive and expressive language difficulties. Each had attended speech and language therapy for a minimum of six weeks, with three attending continuous intervention for numerous years. There was a mixture of experience in public and private sectors. Four participants were from Ireland and one was from the United Kingdom, although individual locations are withheld to protect anonymity due to the small sample size.

Parents also provided brief information about their own and their child's experiences of home practice. These phone meetings were not transcribed as the main purpose was to assist the child interviews rather than get detailed accounts from parents, and therefore information is limited. However, parents' reports contains useful context before delving into the children's views. Parents reported that home practice activities ranged from structured worksheets and app-based tasks to more naturalistic strategies, such as practising skills in everyday routines. In most cases, home practice was explained at the end of sessions, and parents generally reported understanding what to do, although one parent noted having to adapt tasks without support from their SLT to be more suitable for their child. Home practice monitoring was generally described as a "brief check-in". Completion rates varied, with some children completing activities consistently, and others influenced by mood, motivation, or busy schedules. Reported challenges included difficulty motivating the child and "boring" materials, although most parents still viewed home practice as beneficial and important.

Table 8.1 Information Collected from Parents (collected via phone call)

Parent code	P1 (Jack's parent)	P2 (Beth's parent)	P3 (Kevin's parent)	P4 (Nick's parent)	P5 (Randall's parent)
Child Age (at time of interview)	12	11	12	7	9
Child gender	male	female	male	male	male
Description of SLT sessions	Attending continuous private SLT approximately 1-2 times per month for numerous months	Attending continuous private SLT weekly for past 6 years (with breaks). Seeing current SLT for past few months. Attends public service approx. twice a year.	Attending continuous private teletherapy weekly for the past 4 years (with breaks).	Attended a block of 8 weekly sessions through the public service 5 months prior to interview. Also attended another public service block under 2 years ago.	Attended a block of 6 weekly sessions through the public service 4 months prior to interview.
What clinical area did the home practice target?	Reading and spelling	Friendship mentoring and social communication	Speech sounds	Language concepts and semantics	Language comprehension
Description of home practice (type of activities)	Paper-based homework and a game on an app	Practising strategies and social skills in everyday life	Worksheets and power-points	Worksheets e.g., matching, sorting, finishing sentences	Sometimes worksheets, more often parent modelling and practising in the car together
How was it given to you/explained?	It was explained at the end of the session.	SLT tells child directly, and sends summary emails every few weeks to parents	End of the session SLT and parent talked about the home activities	SLT showed and explained homework to parent and child for the last part of the session.	Worksheets given, not always explained. Parent often adapted it themselves.

Did you understand what to do?	Parent sat in on sessions so knew what to do. There was also explanatory videos	yes	yes	yes	Yes but adapted it myself
How often was it completed?	Most or all of the time	Not sure as it was given directly to the child	Some of the time. Sometimes needed to "sneak it in" throughout the day	All the time- mainly because of his good engagement in the sessions at the time.	Dependent on mood
Did the SLT check in/monitor the home practice? How?	Yes spellings were checked each week and then difficult spellings could be revised in the session	SLT occasionally check in at the end of the session, or through email.	Brief check in at the start of the session	SLT would ask about homework before moving on to something else. Difficulties were reviewed for the first part of the session.	Parent/ child usually presented homework at the beginning of session but only limited time for reviewing.
Did you experience any challenges completing home practice?	no	no	Difficult to motivate child	Busy during the week	Child not wanting to complete boring worksheets
Did you find home practice to be useful?	Yes	yes	Sessions were most helpful but homework useful for keeping skills going	Yes- parent saw improvements	It is important but was challenging
Key: SLT= speech and language therapist/therapy					

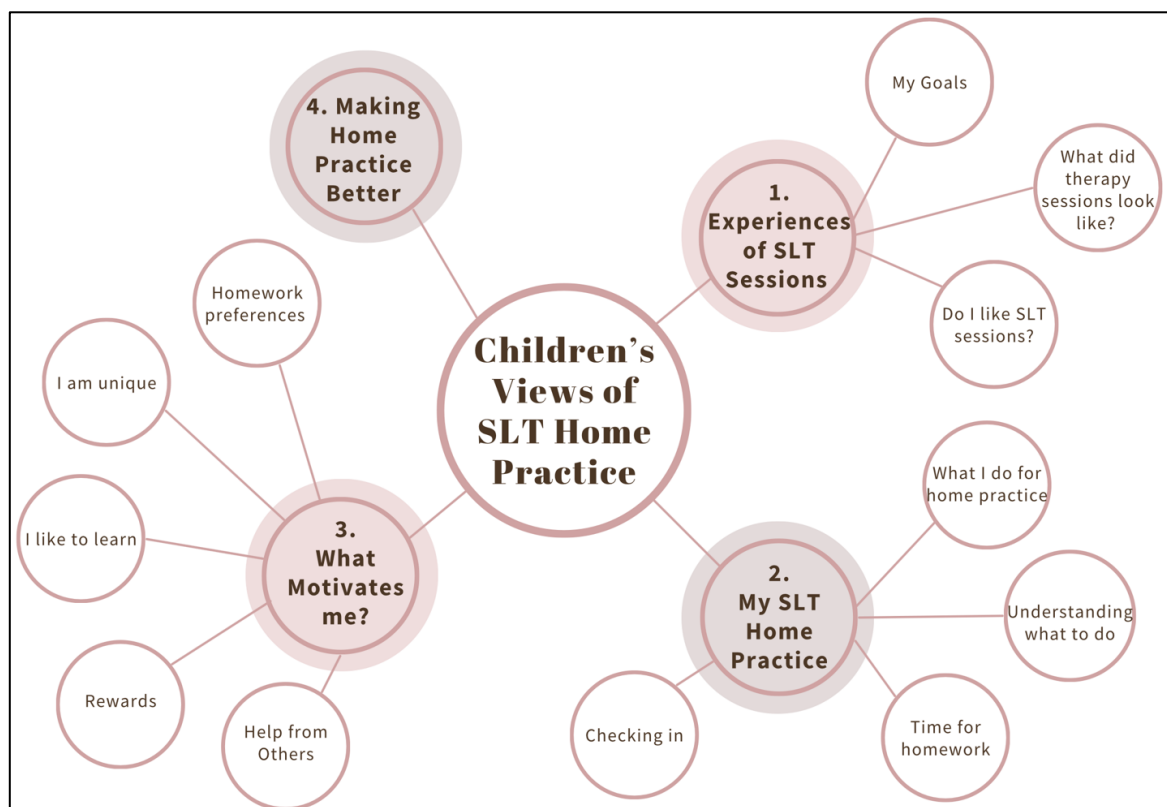
8.2 Findings Overview

Five children participated in interactive interviews that incorporated a range of data collection tools (see table 7.3 in the previous chapter for the name and description of each). Each child had an interview that was tailored to their needs to optimise their participation. The findings are presented under four overarching themes which were generated from the thematic analysis:

- (1) Experiences of Speech and Language Therapy Sessions
- (2) My Speech and Language Therapy Home Practice
- (3) What Motivates Me?
- (4) Making Home Practice Better

The first three themes are comprised of several subthemes. The fourth theme does not consist of subthemes as the codes within it were closely related and too limited to justify further division. An overview of the themes and subthemes is shown in figure 8.1.

Figure 8.1 *Thematic Network of Children's Views of SLT Home Practice*



8.3 Experiences of Speech and Language Therapy Sessions

This theme summarises how children spoke about their experiences with direct intervention. Although the primary research question focuses on home practice rather than on speech and language therapy more broadly, it was clear from the data that children's engagement in home practice was shaped by their overall therapy experience and participation within sessions. Exploring this theme therefore provides important context for understanding the participant's perceptions of home practice. Within this theme, children discuss what areas of communication they worked on, how therapy was organised, and their general feelings toward attending therapy sessions.

8.3.1 My Goals

Participants spoke about what goals they worked toward in therapy sessions, often informed by reflective questions posed after reading the fictional narrative (appendix 12). The participant's ability to express views on therapy goals varied. Two children identified reasons for attending therapy which corresponded with their parents' reports, such as "*spelling and reading*" (Jack) and "*to learn about sarcasm and compliments*" (Beth). However, the other children found it difficult to recall their language and communication goals. For example, Randall could only remember non-speech and language related learning like "*practising tying our laces*" and Nick could not recall at all:

Interviewer (int): did you go for the same reason as Sarah or for a different reason?

Nick: I think it was for a different reason

Int: yeah? Can you think of why?

Nick: yeah... oh no

It is unclear whether these participants were unaware of their speech and language goals due to difficulty recalling them, because therapy goals were not explicitly discussed and explained during therapy, or because they found it difficult to verbally

explain their goals during the interview. However, they described their therapy activities more easily.

8.3.2 What did therapy sessions look like?

Participants described how their intervention sessions were organised. Firstly, they reported attending intervention anywhere from once a week to once a month. Some participants also spoke about their parents attending with them, as Randall recounted “my dad comes since my mom works”.

In terms of therapy setting, three children attended in-person speech and language therapy, one attended teletherapy, and one child had experience with both in-person and online therapy. Beth shared that she enjoys the digital features that come with online therapy:

Int: And what's your favourite thing to do in speech and language therapy?

Beth: I like to play around with the background. That's very cool.

Int: Play around with the backgrounds?

Beth: Yeah.

Int: So what do you mean by that? Does the therapist share something on her screen?

Beth: No, I click on the background thing. And then I can change my background.

Int: Oh, I see. So you like doing that in the sessions?

Beth: Yeah. Mhm.

All children recounted completing table-top activities during their sessions, which related to their parent-reported goals. For example, they reported “breaking down words to spell, and reading” (Jack), “do[ing] a few stories... about friendships and sarcasm” (Beth), and “drawings” (Beth). Kevin, Nick, and Randall were provided with visual options to choose from to help remember their session activities and identified playing games (Kevin), making picture stories (Nick), practising sounds (Nick), and worksheets (Randall) as typical session activities. These descriptions of

session content set the scene for further exploring their attitudes toward attending therapy.

8.3.3 Do I Like Therapy Sessions?

Children expressed contrasting views on therapy enjoyment. Some, like Beth and Kevin, reported looking forward to sessions, with Beth stating, “I like doing it,” and Kevin selecting “I can’t wait to go” when offered a multiple choice question. However, the remaining three participants chose the “in the middle option”, expressing an indifferent view.

Several factors appeared to influence how much the children enjoyed their sessions. For example, session timing was an aspect reflected on by Randall and Jack. Randall found missing school “hard”, particularly when it involved missing out on fun activities such as “cool projects”. However, he also used phrases that implied that missing school did not always bother him, such as “I get to miss school” and “if I’m very good I don’t have to come back to school”. Jack appeared more confident about his view, stating:

Jack: yeah I enjoyed [the sessions] I mean I got to go out school early so that’s another bonus!

These views show that the context and timing of therapy sessions influenced children’s attitudes as well as the session’s content, which was also discussed by participants.

Another therapy aspect which appeared to influence the participant’s enjoyment was the opportunity to play games. All participants except Jack spoke about how they enjoyed playing games with their therapist. These games were often chosen based on the participant’s own personal interests, such as “quiz games” (Beth) and “Pokémon” (Kevin). Beth drew a picture of the slime game she plays at the end of her therapy session, emphasising it’s importance to her (figure 8.2). For Randall, it appeared that playing games was the only aspect of the session he enjoyed, splitting his experience into two parts, the “work” and the “fun”:

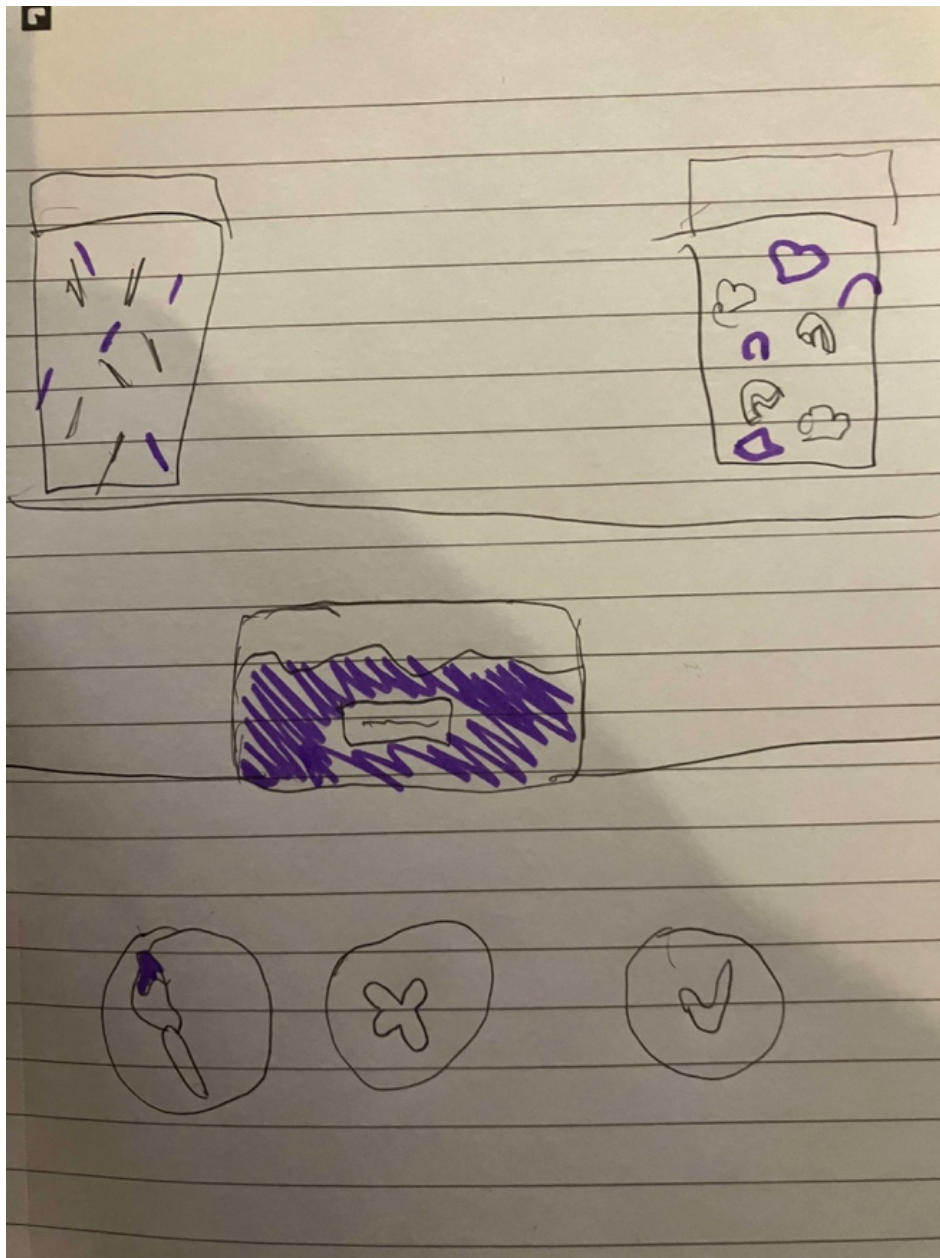
Int: and overall do you think you liked speech and language?

Randall: well it depends if it's kinda fun or if you're doing work

Perhaps due to being older than the other participants, Jack did not report playing games with his therapist, with whom he mainly talked and completed his work.

However the examples given by other participants highlight the key role individualised activities and play have for some children.

Figure 8.2 Beth's Drawing of an online "Slime Game" (She explained "there's slime, and the buttons to change the slime, and sprinkles")



8.4 My Speech and Language Therapy Home Practice

This theme brings together children's accounts of their home practice, including what the activities involved, how they were explained, the extent to which they understood the tasks, and how their work was monitored. These descriptions provide a clearer picture of how home practice was experienced in everyday contexts.

8.4.1 What I Do for Home Practice

Participants' home practice came in a variety of formats. There were three main categories of work described. Firstly, three children reported having a paper-based or a written style of home practice. This included worksheets (Randall), spelling grids (Jack), and cut-and stick activities (Nick). The second category was practice that integrated skills and strategies into everyday routines. For example, Beth's SLT asked her "to do complimenting and saying hello to new people", and Randall practiced new words and making sentences on car journeys with his parent. Only one participant reported a third type of home practice, as Jack discussed completing spelling and reading activities on a website.

Jack: well [SLT] has her website and there's 7 modules... And it's a mix between videos, actual like spelling, and reading.

One participant gave conflicting accounts of the home practice he received. When asked what kind of home practice he was given, Kevin reported that he did not receive any, and when the interviewer presented various visuals to support the conversation (such as worksheets, games, practising words aloud, flashcards etc.) he answered "no" to each. However, he later spoke about not enjoying home practice and noted that some words were harder to practice than others. It is unclear what caused this discrepancy. It is possible that he felt uncomfortable discussing the homework in the moment, that he did not consider the visuals to be an accurate representation of his tasks, or as shown in the excerpt below, perhaps he felt that the homework was assigned to his parent rather than himself:

Int: [playing true or false game about speech and language therapy and home practice] So at the end of the session [SLT name] gives me a game or activity to practice with my dad.

Kevin: I'm telling you it's false!

P3: she gives... she gives me the game isn't it?

Int: ohh

Kevin: yes

Int: OK interesting so she gives your dad the game to play... so then do you play the game with your dad afterwards?

Kevin: yes

These responses indicate that Kevin may not have been fully aware of the purpose of home practice or why it was given. Kevin's parent also explained in the parent meeting that home practice sometimes had to be "sneaked in" for Kevin to engage. His understanding of the purpose of home practice and what he was expected to do may have been influenced by how the tasks were explained to him, which is further explored in the next subtheme.

8.4.2 Understanding What to Do

Three participants described how home practice tasks were explained to them, highlighting a range of approaches used by their SLTs. For Jack, Beth, and Randall, verbal instructions were provided by the therapist. This was the only method Beth and Randall described, as Beth explained "she just tells me at the end of the session". However, Jack also reported that written and video instructions were useful.

Int: OK and what helped it to be easy to understand?

Jack: she would send... so we have like a folder and she would give us like one or two sheets telling us what to do.

Int: OK and that would have instructions, on the sheets?

Jack: Definitely

Int: OK very good that's interesting. And you said that there was videos as well on the modules?

Jack: yeah there was. That was very helpful because it would actually tell you- it would take a rule from spelling and then tell you about it and then tell you what to do with it.

Written instructions were also valued by Nick, who explained that worksheets were helpful because “it [the worksheet] said what to do,” making the task “pretty easy” to follow. Kevin was the only participant who did not report how home practice was explained, which in light of the parent report in Table 8.1, may reflect that the explanation was directed to his parent rather than to him. Overall, children’s accounts suggested that clear explanations and accessible instructions supported their understanding of home practice.

8.4.3 Time for Homework

Children also spoke about the frequency, amount, and timing of their home practice, describing how often they were expected to complete activities and how these tasks fit into their daily routines.

All participants reported receiving home practice in most or all of their therapy sessions, and that they were expected to do their practice multiple times throughout the week. Although Jack and Randall both reported having to do homework “every day”, they both explained the importance of taking breaks from home practice when they were tired, over the weekend, and on days they attended therapy.

Jack: we didn't do it on weekends though

Jack: we don't do homework on those days [after SLT sessions]

Randall: [I do homework] maybe once every day, But when I'm very tired... no I don't really do it.

However, each participant’s homework routine was different. Children reported doing their practice at different times of the day and week, including

straight after school (Jack, Kevin, and Nick), over the weekend (Nick), during school (Jack, Beth), and on car journeys (Randall). Only one participant remembered how long home practice took to complete, as Jack reported about 15 minutes each time. As children described the different ways they fit home practice into their routines, it raised questions about the extent to which their SLT supported them in identifying ways to incorporate these activities into everyday life.

8.4.4 Checking In

Only one participant discussed how home practice was monitored. Jack reported that his therapist discussed his written homework with him at the start of each session, and adjusted subsequent work based on Jack's feedback.

Jack: [the SLT] would just ask like "how are you getting on with the homework, is it too easy or is it too hard?"

Int: OK so she checked in

Jack: yeah

Int: did you find that helpful?

Jack: I found that very helpful because sometimes it would be too hard and then she would like give us something easier.

Jack reported that his online homework was more self-monitored, but was aided by audio feedback on the website. He explained that he would attempt to read a word aloud, then press a button to hear the word which he could compare with his own attempt. Jack reported preferring his written homework over the online work, perhaps motivated by the support provided by his therapist described above. However, participants described a variety of other factors shaping their motivation, outlined in the next theme.

8.5 What Motivates Me?

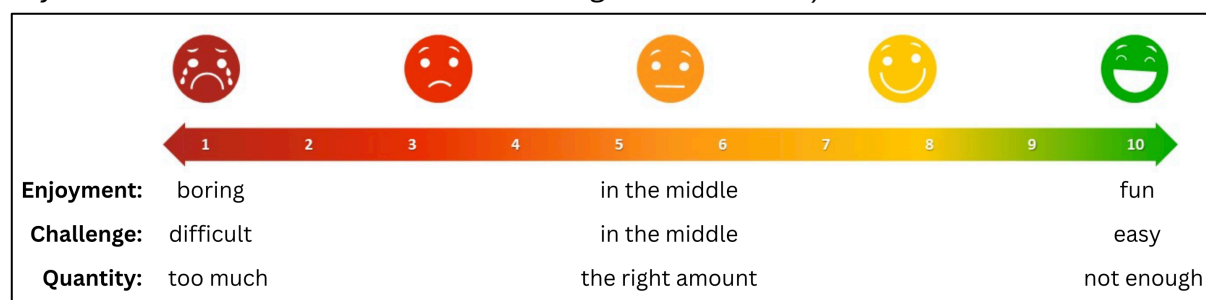
This theme captures how children described their motivation to engage with home practice, including activities they enjoyed, challenges related to difficulty and

effort, their desire to learn and improve, and the influence of external rewards. Views were varied, highlighting that motivation was shaped by each child’s individual preferences, routines, and perceptions of the tasks.

8.5.1 Homework Preferences

As participatory methods were adapted within and across interviews, participants used a range of ways to explain their feelings about different aspects of home practice, such as verbal comments, rating scales, written multiple choice questions, and a combination of all (see table 7.3 for descriptions) Figure 7.2 is also copied below as a reminder of the rating scales used.

Repeat of Figure 7.2: *Visual Rating Scale Used During Interviews (with examples of key words interviewer said and wrote during the discussion)*



The participants had mixed views on whether or not home practice was enjoyable. While two children rated it as “ fun” (Nick) and “exciting” because “it’s fun to try out stuff” (Beth), another child indicated a strong dislike of home practice, describing it as “torture” (Kevin). Expressing more moderate views, Jack and Randall rated their written homework a 4-5 on the enjoyment scale. The type of tasks he was given appeared to influence Randall’s enjoyment however, as he explained how his casual practice in the car with his dad was more fun than the written homework.

Randall: we have little jokes so I’m gonna put it at like a number 9 [on the enjoyment scale]

Participants also had mixed opinions on how easy or challenging their home practice was. The same children who reported that the homework was fun (Beth,

Nick, and Randall's car practice), also rated their homework as "easy" rating it a 9-10 on the challenge scale. However, for Randall easy homework did not mean he was motivated to engage:

Int: 10, so it was super easy?

Randall: yeah but I didn't wanna do it... I didn't like doing it

Jack and Kevin who scored lower on the enjoyment scale also felt it was more difficult, rating their homework a 6 and 5 on the challenge scale, respectively. Randall explained that practice is "harder on some words", and Jack felt that homework had to be somewhat challenging in order to learn new things. Jack reported that a 6 on the challenge scale is the ideal rating, as if it was any more difficult it would discourage him from practising:

Jack: if it was too hard I wouldn't like it as much... I wouldn't want to be doing it. I think that's the big thing, you need to want to do it.

Similarly, Jack also felt that there was a link between the enjoyment level and his perception of how effective it was:

Int: do you think there would be anything that your speech and language therapist could have done to make it more fun?

Jack: no no I don't think so because if it was too fun it wouldn't be... it wouldn't be as effective

Int: you don't think so?

Jack: mmm well I would want to do more but I doubt would be as effective

Int: and why do you think that?

Jack: because if it's like too fun, like if I'm just playing games I'm not really gonna learn how to spell

Int: OK so it has to be challenging?

Jack: a little bit challenging yeah. I like when something's like a little challenging

Although Jack suggested that more “fun” activities would be motivating, he reported that less engaging tasks had still been effective, suggesting that he perceived a need for activities to be less enjoyable to achieve progress.

Finally, children also had varying views on the quantity of home practice they received. Although most children could not remember a specific quantity, Jack and Nick described the amount of home practice they received as “the perfect amount” and “enough”, respectively, while Beth scored it a six on the quantity scale. However the other two participants felt that they were given “too much” (Randall), which “takes too long” (Kevin). Participants’ feelings on homework quantity also depended on their energy levels on a particular day, or if they also received a lot of school homework.

Jack: if I’ve had like a lot of homework I wouldn’t really like to be doing it.

It is clear from these responses that views related to enjoyment, challenge, and homework quantity varied both across participants children and even within individual children. Their preferences shifted depending on the activity, what else occurred in the day, and their mood.

8.5.2 I Am Unique

Two participants spoke about the importance of home practice being tailored to their specific difficulties. Jack discussed finding speech and language homework better and more enjoyable than school homework because the former is “more directed at you”. He explained that it can target challenging areas, and the difficulty level can be adjusted. A similar sentiment was discussed by Randall when asked what home practice he would assign a child if he was an SLT:

Randall: well depends what they’re not really good at and what they’re good at... so if they weren’t good at counting I would ask them to practise their counting.

These responses suggest that although tasks could be challenging, participants valued home practice that addressed areas of difficulty in a personalised and targeted way.

8.5.3 I Like to Learn

Participants spoke about how a desire to improve their communication skills motivated them to complete home practice. While some participants felt that therapy sessions were more enjoyable and “helped more” (Randall) than practising at home, most still recognised that home practice was intended to support progress toward their goals. When discussing the fictional narrative, Nick and Randall recognised that the main character Sarah completed her homework because she wanted to improve her vocabulary. Similar ideas were expressed when children reflected on their own experiences, however perceptions of progress were mixed. Nick felt that he had “stayed the same,” whereas Jack, Beth, and Randall reported improvements, as Beth noted that her goal of understanding sarcasm “has gotten easier” because of home practice.

This progress appeared to be motivating for some participants and encouraged them to practise more. The feeling of confidence and independence was particularly salient for Jack:

Int: What about the home practice made you want to do it?

Jack: because I like the feeling of getting something done... I like when- when I was not able to read at all, like, it was really hard for me. I liked when I was able to, you know, read with confidence.

For him it was worth overcoming the challenges associated with home practice in order to achieve this confidence, as he further explained when giving advice to a hypothetical child who just started their speech and language therapy journey:

Jack: I'd just tell them it's gonna be hard for like a while. But when you do, it'll just click at one point. It doesn't matter if it takes like a month or two years. It'll take a while but it'll click at one point.

Int: yeah OK and you'll get it then?

Jack: yeah it'll be way easier. It already like kind of clicked with me for the reading, so I'm just working on spelling now.

This feeling of achievement appeared to support children's ongoing engagement with home practice.

8.5.4 Rewards

Using the "Dog Man" written multiple choice booklet (Appendix 13), Kevin and Nick discussed what helped them to complete their homework. Options included receiving a reward, turning homework into a game, practising with family or friends, doing homework on an iPad or phone, or "something else". They were encouraged to pick as many options as they wanted, however both only chose "rewards". They suggested "playing a game at the end" (Kevin) and receiving a "medal" or "stickers" (Nick) as rewards. It is possible that their selections were influenced by the options presented, and that children's prior experience with rewards-based systems in speech and language therapy or other areas made this an appealing choice. Notably, no other participant brought up the idea of rewards spontaneously. Additionally, although "practising with family or friends" was not chosen at this time, participants did speak about the support provided by others during their intervention.

8.5.5 Help from Others

Children spoke about people in their environment who supported and encouraged their participation in home practice. The most frequently reported supportive person was the participants' SLT. Across interviews, children spoke positively about their therapists, often highlighting qualities that helped them feel supported and motivated. For some, this centred on the therapist's expertise and ability to teach them new skills, as Jack explained:

Jack: I think she kind of just knew everything that I needed to get better at, so she was really good at teaching me that stuff.

For others, the therapist's personal qualities were equally as important, as Beth described her therapist simply as "kind". Meanwhile, Kevin recalled his therapist's physical traits to help remember the activities and discussions they had together, such as her hair colour and clothes. Children's descriptions suggest that their relationship with the therapist affected how supported they felt.

Beyond their SLTs, most participants also described receiving support from their parents to complete home practice. All participants except Beth reported doing activities with their parents or asking them for help when unsure. Jack explained that when he is confused he would "probably just ask mam... she would do it with me".

In contrast, support from peers was not as commonly reported. Although Jack occasionally completed online home practice with another child during school, Beth and Randall preferred not to tell their friends about their speech and language therapy sessions or practice. Although neither child elaborated on why, "I'm not sure, I just don't [want to tell friends]" (Randall), participants potentially felt more comfortable receiving support from adults who understood their needs such as their therapist and parents.

8.6 Making Homework Better

In addition to describing their experiences, children also shared ideas about how home practice could be improved. This theme summarises their suggestions on what they would find enjoyable, motivating, and relevant to their own interests.

Some participants appeared generally content with their current home practice, as Jack, Beth, and Nick initially stated that they would not wish for any modifications or enhancements. However, once children were prompted with further questions, provided with an opportunity to draw pictures, or took part in a visual sorting exercise, participants expressed some ideas on what would make home practice more fun or engaging.

Nick and Randall engaged in the visual sorting exercise, categorising given visuals according to whether they would or would not like them to be assigned as

home practice (see Appendix 14 for visuals). Nick responded positively to worksheets, phone or iPad apps, board games, practising strategies at home, and reading books, whereas talking aloud, flashcards, and practising strategies at school were viewed less favourably. Randall had almost identical preferences, with the exception of reading which he reported he would not enjoy. Their preference of practising strategies at home rather than at school could potentially be related to children's earlier report of not wanting to tell their peers about speech and language therapy:

Nick: I don't like practising at school

Int: you don't? why not?

Nick: because it's boring!

Int: so you prefer practising at home?

Nick: yes

While Randall expressed interest in numerous activities listed above, he also emphasised the need for variety within home practice, suggesting to "change it up every week". This sentiment was echoed by Jack, as he recommended "not doing the same thing every day". Ideas on how to increase variety and engagement appeared in other participant's accounts, expressed in different creative forms.

Kevin depicted his ideal homework through a drawing (figure 8.4). His novel idea included using an artificial intelligence (AI) website such as ChatGPT as a platform for learning and asking questions. He explained that the characters in the picture represent himself and another character created by his classmate, who both love ChatGPT:

Int: And you're both doing [homework] together?

Kevin: yeah since we are lovers of ChatGPT.

Int: brilliant! And what do you think you could do on ChatGPT about speech and language do you think?

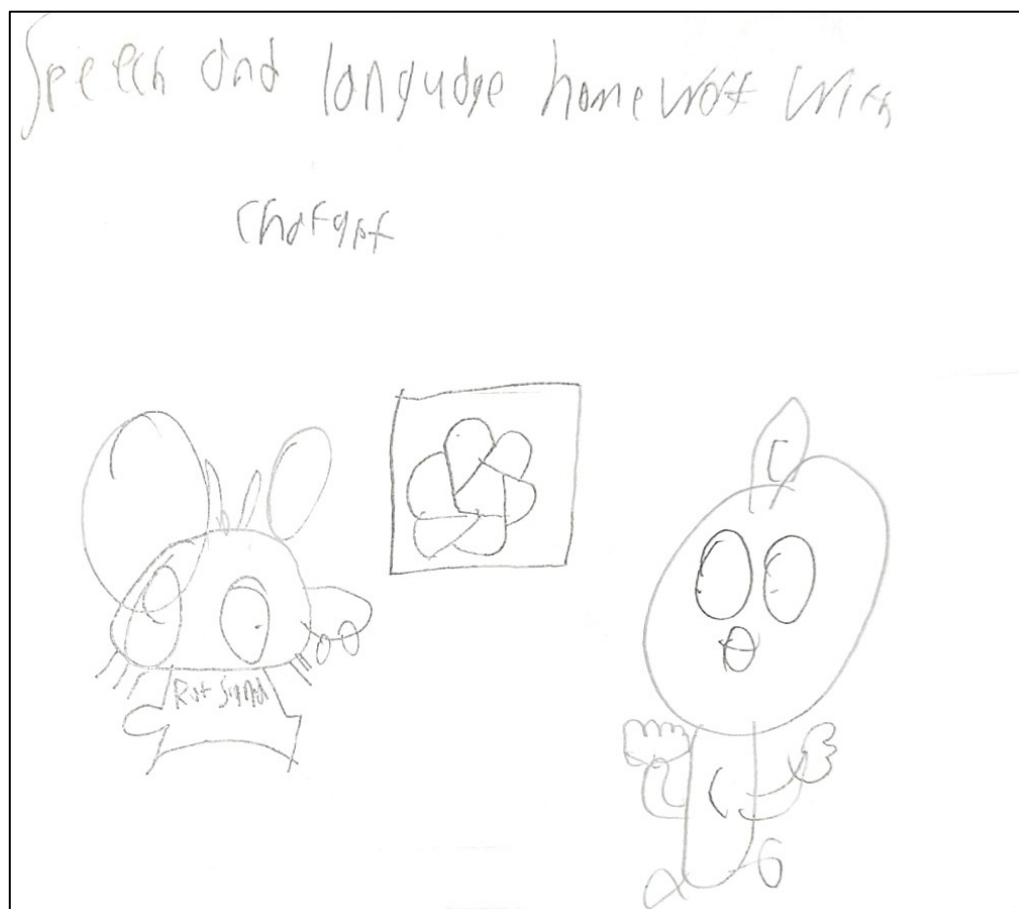
Kevin: ask it like "how to pronounce please"

Int: ahh ok so you could ask it questions

Randall had similar ideas for online learning, explaining that he “usually hear[s] new words in YouTube videos and that helps”, even perceiving it to be more useful than the work assigned by his therapist. Despite their unique ideas however, Kevin, Nick, and Randall all made it clear that their ideal scenario would be to have no home practice at all. Randall attributed his reluctance to being “lazy”, explaining that sometimes regardless of the activity type, “you just don’t want to work on anything”.

Finally, participants were invited to suggest an appropriate name for home practice. Expressing his negative feelings toward homework, Kevin suggested “homework of torture”. Other suggestions included *homework* “because you’re at home and you’re doing work!” (Randall), *activities* (Nick), and *practising* “because it’s more like practising and you already do homework in school” (Beth).

Figure 8.3 Kevin’s Drawing of Ideal Speech and Language Therapy Home Practice (including the ChatGPT Logo, a character representing himself (right) and a fictional character called Rat Sigma created by Kevin’s peer (left).)



8.7 Methodological Insights

In addition to presenting thematic findings, this section outlines methodological insights that emerged during the research process, as these shaped how children engaged with and contributed to the study.

A key finding of this study from a methodology perspective was that children responded differently to the different methods used within their interview. This finding highlights the importance of giving choice and having flexible options. For example, Jack felt confident in verbally expressing his views, whereas drawing helped Beth express her views on enjoyable parts of intervention (Figure 8.2). Allowing children to choose how they engaged, rather than directing them toward a particular activity, appeared to support their sense of autonomy. For example, when the interviewer initially explained to Kevin that drawing was an available option, he expressed that drawing is “for babies” and did not want to engage. However, he later completed a drawing on his own accord when he was not prompted by the interviewer, which resulted in further discussion of a topic he initially found difficult to describe (ChatGPT). Although a topic guide was used to stay within the relevant subject area, it was also important to allow children to guide the both the conversation and ways in which they respond.

Another reflection arising from this study relates to the impact of researcher positionality. The interviewer’s professional background as an SLT facilitated the ability to adapt communication in real time in response to children’s needs. Researchers from other disciplines may find this more challenging without appropriate training, which may lead to children with SLCN being underrepresented or inadequately supported in research studies. At the same time, it was necessary to critically reflect on other aspects of research positionality such as the inherent power imbalance between child and adult, and the researcher’s professional background. The use of reflective logs throughout the study (see Chapter 7) supported ongoing awareness of these dynamics and informed a more reflexive research approach.

8.8 Chapter 8 Summary

Overall, the interviews highlighted considerable variation in how children experienced and engaged with home practice, with these experiences closely linked to how therapy was structured and explained. Children's understanding of their goals and of the purpose of home practice was inconsistent, and in some cases practice appeared to be directed more toward parents than the child. Home practice activities differed widely in what it looked like and how children completed it, with most children fitting tasks into their routines or completing structured written tasks.

Motivators to complete home practice were also varied and shaped by multiple factors including enjoyment, perceived difficulty, the quantity of work, and the extent to which activities were tailored to the child's needs and interests. Some children valued home practice as a way to improve their skills, gain confidence, or achieve greater independence, while others found it challenging and disliked it. Support from parents and therapists played an important role in facilitating engagement.

Children's suggestions for improvement emphasised variety, choice, and the use of online tools, reflecting a preference for activities that felt enjoyable and relevant to their everyday lives. Overall, this study's results suggest that children are more likely to engage with home practice when it is clearly explained, personalised, and supported within their routines.

Section Four:

Discussion and Conclusions

Chapter 9: Integrated Discussion of Key Findings

9.1 Introduction

This chapter aims to bring together the findings from the two studies presented in this thesis: a systematic review (SR) of children's perspectives of speech and language therapy service delivery, and a child interview study (CIS) exploring children's views of home practice (will be referred to as SR and CIS throughout this chapter). These studies sought to understand how children experience speech and language therapy in relation to their expectations, roles, participation, motivation, and perspectives of practical and organisational factors. While the SR strived to synthesise the current available research on children's views of service delivery in a broader sense, the CIS aimed to contribute new findings to the specific area of home practice. Five key findings are discussed in this chapter, summarised below before being discussed in more detail in proceeding sections.

9.2 Key Findings Overview

The first striking finding of this study is the lack of research on home practice, particularly from the child's perspective, despite its central role in speech and language therapy. As outlined in Chapter 2, the majority of parents and SLTs report home practice being a large part of intervention, with both groups recognising clear benefits such as increasing practice opportunities and supporting skill generalisation (Doherty et al., 2025; Klatte et al., 2023; Sugden et al., 2018). However, only a small number of studies have explored parent and clinician perspectives, and only three studies in the SR included children's views on the topic. Both children and adult perspectives highlight challenges engaging in home practice, displaying a clear disparity between its potential benefits and how it is currently being used and understood (Doherty et al. 2025; Sugden et al., 2019; Watts Pappas et al., 2008). One potential hypothesis for this disparity is the current framing of home practice as a means to increase dosage in under-resourced

services, putting undue pressure on families to complete an impractical amount of challenging home practice and leaving SLTs little time to support them. However, children's insights suggest a need to reconsider how home practice is currently conceptualised.

From a behaviour change perspective, it is unrealistic to expect children to engage in new, challenging activities without setting them up for success in initial stages of therapy, such as exploring their readiness to change, self-perceptions, and hopes for therapy (Prochaska & DiClemente, 1983). However, the second key finding is that children are routinely being left out of goal-setting and discussions about expectations, potentially limiting their chance of successful engagement. Similarly, children appeared more motivated to engage if home practice considered autonomy, competence, and relatedness by involving them in decisions, supporting them to recognise progress, encouraging others to support them, and fostering early positive and successful home practice experiences (key finding 3) (Deci & Ryan, 1985). A fourth key finding also relates to motivation and engagement, but focuses on the importance of integrating fun and games into therapy and home practice, as this theme was one of the most consistently discussed across the SR and CIS. These three findings suggest a need to move away from viewing home practice as a short-term means of increasing dosage, and instead consider it as a longer term investment into supporting children's communication and social development. Greater emphasis may be needed on building children's involvement, confidence, and enjoyment before introducing more demanding expectations, and further research is needed to understand how this reconceptualisation might influence outcomes over time.

The final key point relates to a practical barrier to this shift, as it is acknowledged that SLTs are not always positioned to provide the level of support families may need for successful home practice. Children's accounts highlighted the important role parents play in facilitating home practice, yet it is clear that parents do not always feel adequately supported in this role. These findings raise the possibility of moving toward a coaching model of practice, where more emphasis is placed on guiding families to develop confidence and independence, rather than

relying primarily on therapist-led approaches. The remainder of this chapter considers each of these key points in greater detail and the following chapter explores their implications for practice and research.

9.3 Key Finding 1: Home Practice is Under-Researched and Under-Utilised.

Home practice is a central part of speech and language therapy, with the majority of SLTs and families in Ireland, Australia, and the United States reporting it being a part of intervention (Doherty et al., 2025; Sugden et al., 2018; Tambyraja, 2020; Watts Pappas et al., 2008). Reported benefits of home practice are its ability to increase practice dosage, facilitate generalisation of skills, and promote self-management (Doherty et al., 2025; Sugden et al., 2018). However, the SR only found three studies which referred to children's views of home practice (Alighieri et al., 2023; Braden et al., 2018; Hearne et al., 2008). Home practice was not a central topic of these studies, rather a small section of their results. Additionally, home practice was unanimously disliked by participants. These three studies, alongside insights from the CIS and existing literature on adult views, show that there is a gap between the potential benefits of home practice and how it is currently being used. This key finding highlights these gaps, with subsequent sections offering a more nuanced discussion of potential approaches to address these challenges.

9.3.1 Dosage

Home practice is often used by SLTs to increase practice dosage to improve the quality of intervention and accelerate outcomes for children (Doherty et al., 2025; Sims, 2015; Sugden et al., 2018). For example, a child receiving six weekly sessions with 100 teaching episodes per session would complete 600 episodes, which could increase by 50% if parents delivered an additional 50 teaching episodes between sessions. Although optimal dosage is not always clearly defined for speech and language interventions, research suggests that increasing the amount of practice is often associated with better outcomes for children with SSDs and some language difficulties, up to a point where further increases produce smaller or no

additional benefits (Allen, 2013; Baker, 2012; Williams, 2012). Regardless, this study's findings reveal that successfully increasing dosage is more complex than handing families extra work without adequately supporting its completion. For example, participants in the SR found it difficult to balance speech and language home practice with other activities and commitments (Braden et al., 2018; Hearne et al., 2008). Some interview participants such as Kevin and Randall agreed, feeling that the quantity of home practice was excessive. They identified difficulties balancing their school homework, feeling motivated when tired, and emphasised the importance of taking breaks and days off practice. In terms of parent views, some felt they received an adequate amount, while others echoed challenges of balancing other life commitments (Doherty et al., 2025; Sugden et al., 2019). However, as Warren et al. (2007) discuss, the quality of the teaching episodes is also an important factor when considering dosage and dosage effectiveness. Even if parents felt the quantity was ideal, they often did not feel confident or adequately guided by their SLT to support their child at home (Doherty et al., 2025; Klatte et al., 2024; Sugden et al., 2019). These experiences are likely influenced by therapist challenges, such as the reported lack of time and support to create activities and follow up with families (Doherty et al., 2025). This lack of confidence and support can contribute to emotional strain within families and children may internalise these difficulties, as illustrated by Randall describing himself as "lazy."

SLTs may also feel under additional pressure to increase practice dosage through home practice when working in services which cannot provide evidence-based dosage recommendations through direct intervention due to under resourced facilities and long waiting lists (O'Toole et al., 2025; RCSLT, 2024; Sherlock, 2025). Both SLTs and parents have expressed frustration at the lack of services available to families, and home practice is often considered the most feasible means of increasing dosage in less than ideal conditions (O'Shea et al., 2024; Sims, 2015). Consequently, the expectations placed on families to complete a large amount of home practice is likely high, possibly adding to the pressure and burden that is being reported by parents and potentially impacting children's experiences of it also. This points to a need to be more considerate of complexities such as dosage quality, as

well as other aspects of intensity such as dose form, distribution over time, and the context and environment in which the teaching episodes are being carried out. It is therefore important to explore more into these different perspectives such as the benefits of increasing dosage through home practice, the barriers to engagement, and what steps can be taken to provide more support to families (Doherty et al., 2025; Sugden et al., 2018; Sugden et al., 2019).

9.3.2 Generalisation and Self-Management

Aside from dosage, home practice also offers the potential to support skill generalisation beyond the clinic environment. Generalisation and maintenance of skills was considered a vital yet challenging aspect of intervention by participants in the SR (Braden et al., 2018; Hearne et al., 2008). Children's reflections of the fictional narrative presented to them in their interviews indicated that they understood home practice helped the main character use her newly developed vocabulary and language skills with friends. In terms of their own experiences, some participants such as Jack reflected on how improvement of skills led to increased confidence with spelling, while others such as Nick felt that his skills remained "the same" as before therapy. Participants did not generally discuss how they used their skills in other aspects of their life such as social experiences or academic work, except Beth who briefly mentioned that identifying sarcasm when talking to friends had gotten easier.

These limited insights which focused more on completing activities rather than the work's impact on communication more generally may reflect that intervention and home practice are currently being framed in an impairment-based or medical model (Abrahams et al., 2019). As the field of speech and language therapy has moved toward social models of disability, more emphasis is placed on the functional aspects of intervention, such as working toward meaningful goals and promoting community involvement (Duchan, 2001; WHO, 2001). However, children may not have discussed the impact of home practice on these social or functional aspects because their activities were primarily focused on addressing specific impairments rather than on goals that felt meaningful to them, highlighting the

importance of involving children more actively in goal setting (more in Key Finding 2). Another possibility is that children were not sufficiently supported to identify and monitor changes in their skills or progress toward goals, and therefore did not recognise these developments. This suggests a need to involve children more in discussions about progress, helping them to understand and reflect on how their skills generalise beyond therapy sessions.

Generalisation is closely linked to the concept of self-management, as children can only take an active role in managing their communication when they are able to apply skills beyond the therapy sessions. Self-management refers to the actions taken by an individual to take care of their own health and wellbeing (Panagioti et al., 2014). Home practice can provide opportunities for children and their families to apply learning and strategies outside of direct therapy, making it a suitable means to encourage and develop self-management. Many children with SLCN, such as those with DLD, autism, stutter, or who use AAC, require ongoing support as their communication needs evolve across the lifespan (Shivers et al., 2019). As with other long-term and chronic conditions, promoting self-management is important for reducing reliance on services, managing emotional wellbeing, and empowering families (Nichol et al., 2023), while also contributing to service sustainability and cost efficiency (Panagioti et al., 2014).

However, findings from both the SR and CIS suggest that home practice is not currently being used to its full potential as a tool for either generalisation, self-management or increasing dosage. The experiences reported by children and their families highlight three main challenges to address. First, there is a need to consider how children's motivation and willingness to engage with intervention and home practice can be improved, including making activities easier to integrate into daily routines, more enjoyable, and supportive of habit formation (Key Findings 2-4). Secondly we must explore how families can be supported to implement these changes in a way that reduces emotional burden placed on parents (Key Finding 5). Thirdly, addressing the lack of children's voices in service design and research may provide insights into how listening to children could enhance services and experiences of professionals and families (Chapter 10).

9.4 Key Finding 2: Engagement Starts with Setting Expectations and Goals

9.4.1 What is Engagement?

Before considering how ‘engagement’ with home practice can be supported, it is important to clarify what is meant by the term. Traditionally engagement has referred to aspects such as client attendance, participation in the session, completion of home practice, compliance, and making progress (Staudt, 2007). However, recently engagement is viewed more as a collaborative, multidimensional process shaped by a person’s affect, behaviour, and their therapeutic relationships, hence reducing the burden of engagement being the responsibility of service users only (Bright et al., 2015; Melvin et al., 2021). In other words, collaboration between professionals, clients, and families is needed to cultivate engagement, which interacts with the children and families beliefs, values, feelings, and participation. Throughout this study, children’s ‘engagement’ is understood as their involvement not only in completing activities but also in intervention processes like making decisions, expressing views, and reflecting on change. The extent to which SLTs facilitate this involvement and meaningfully incorporate children’s views is also considered when discussing engagement. Much of this participation tends to start in the initial stages of intervention, such as managing the child’s expectations of what therapy entails and setting initial goals. It is therefore important to explore how this initial engagement can be supported.

9.4.2 Understanding the Purpose of Therapy and Home Practice

The SR provided some context for how children experience the early stages of their intervention, including their expectations for therapy and their role in the goal-setting process. The findings showed that while some children understood why they were attending therapy, many others did not understand the purpose or have a clear grasp on their own therapy goals (Alighieri et al., 2023; Braden et al., 2018; Fourie et al., 2011; Merrick & Roulstone, 2011; Owen et al., 2004). Likewise, participants such as Kevin, Nick, and Randall had difficulty recalling their speech and language related

goals. Perhaps the abstract concept of goals was a difficult concept for children to describe across the studies, as they more accurately discussed concrete aspects of their intervention such as activities, structure, and routines. However it may be the case that this limited understanding is caused by immediately introducing therapy approaches and activities, rather than first discussing therapy purpose and goals. Similarly in the context of home practice, most participants either had a shallow understanding that home practice can “help you get better at talking” (Beth, Nick, Randall), or did not appear to understand the purpose of home practice at all (Kevin). This confusion was evident when Kevin explained that home practice was actually for his parent to complete, rather than for himself. Jack appeared to have a better understanding of the purpose of home practice when he explained that it helped “lodge” the concepts and that just attending the sessions alone “wouldn’t have done anything” without home practice. It is unclear if Jack came to this conclusion on his own or if this was a discussion he had with his SLT, however understanding the benefits of home practice appeared to help motivate him to complete the activities, even when he did not enjoy doing it.

Given that many children begin intervention without a clear understanding of the purpose of therapy or home practice, it is unsurprising that some children experienced difficulties with changing habits and integrating home practice into their daily routines. Behaviour change theories such as the five stages in the transtheoretical model of change may help explain these difficulties (Prochaska & DiClemente, 1983) (see section 1.3.6 for more). A person in the first ‘precontemplation’ stage either has no awareness that change needs to occur, no intention of implementing change, or feels that they cannot be helped (Zebrowski et al., 2021). It appears that many children were in this stage when they started therapy, especially when it was their parents decision for them to attend. Expecting children to jump straight into willing participation and completion of challenging home practice activities is unrealistic and skips some key steps, according to this theory, and mismatch between client stage and approach used is often why behaviour based treatments fail (Van Leer et al., 2008). In order to start the process positively, initial goals could focus on supporting the child to reach a stage where

they are ready for change, addressing the contemplation and preparation stages before expecting action. For example, identifying the child's current understanding of their communication strengths and difficulties, reflecting on where challenges occur in their daily lives, and identifying areas the child would like to target. Similar strategies have been effective with adults in voice therapy and adolescents who stutter (Rodgers et al., 2021; Van Leer et al., 2008). It is also important at this stage to place confidence in the child that engagement in therapy and home practice can have a positive impact (Zebrowski et al., 2021). Providing education and rationale for why home practice is beneficial could help them to place value on engagement from early on.

9.4.3 Goal-Setting

According to the transtheoretical model, once the child reaches the preparation stage, they show intention to engage in behaviour changes such as attending therapy and completing home practice activities (Prochaska & DiClemente, 1983). At this stage, it is more appropriate to facilitate structured goal setting that aligns with the child and family's aims. Goal setting was very minimally discussed in the SR, showing that it is an area that requires more research. The only participant who spoke about setting goals in Brauner et al.'s (2025) study described feeling excluded from the conversation and having to look at his treatment plan "secretly". Similarly, when discussing home practice, children usually described being "told" what to do (Jack), rather than being involved in the planning process. Without meaningful inclusion in goal setting, there is a risk that service provision fails to remain family-centred and neurodiversity affirming (Dunst, 2002; Dunst et al., 1991; Dwyer, 2022). The family-centred model explains that one of the SLT's roles is to support clients and their families to make their own informed decisions regarding their care (Dunst, 2002). As parents and guardians are typically responsible for making health-related decisions on behalf of their children, they are consulted more often than children when making decisions (Coyne et al., 2014). However, even from parent's perspectives practice often remains professionally-centred or family-allied, indicating parents still feel that the SLT leads decisions

(Biggs et al., 2024). This disparity appears even larger in terms of centring children in decision-making, despite them being the receiver of the intervention. When children are excluded from goal setting, therapy may also become less neuro-affirming by prioritising impairment-focused targets over the child's own values and identity (Gaddy & Crow, 2023).

Children's perspectives provided practical suggestions for incorporating them more actively in goal setting and decision-making during the early stages of intervention. Firstly, children emphasised the importance of knowing what to expect (Alighieri et al., 2023; Owen et al., 2004), highlighting the benefit of establishing shared expectations from the start. For example, a collaboratively designed "homework agreement" could be used to define roles, negotiate how much time will be dedicated to home practice, and express activity preferences. Secondly, children highlighted the need to balance home practice with their broader daily commitments, which included being given days to rest. This flexibility could be incorporated into the agreement, while maintaining specific expectations. For example, it could specify some agreed options such as reducing or removing home practice on particularly demanding days, having a set number of opportunities to refuse to do home practice, or allowing the child to choose the times to practice in advance. Thirdly, as earlier described, children sometimes had limited insight into how home practice could support them to use skills in broader contexts and monitor these changes. More time in therapy sessions could potentially be used for reflective discussions with the child and family to consolidate their understanding of the benefit of home practice and identify progress or challenges encountered. Using a visual format could help facilitate this monitoring by allowing comparison between the plan and how it was actually completed, and create opportunities for the SLT and family to adjust tasks and problem-solve. Collaborative goal setting and monitoring may help children feel heard and more confident in their ability to succeed with home practice.

It should be acknowledged that approaching engagement by addressing the child's awareness of their difficulties, therapy purpose, and intention to engage in behaviour change requires quite high-level language and reasoning that many

children with SLCN may find challenging. For older children or adolescents perhaps with SSD, stuttering, or voice difficulties, the approaches discussed above may be ideal. For others with language difficulties, it is important to adapt these conversations to accommodate their needs. Using visual supports, visual scales, sorting exercises, or questionnaires, such as those used in the CIS methods, could be useful. For example, in the CIS Nick and Randall successfully sorted visuals to help them express which activities they would or would not enjoy, suggesting that similar supported communication approaches could facilitate shared decision-making (see Appendix 14 for visuals used). That being said, spending a significant amount of time at this stage may not be appropriate for all children, for example very young children or those with more severe cognitive difficulties. In these cases, developing a holistic understanding of the child's strengths, needs, and opportunities for development may rely more heavily on observation in different contexts or input from others within the child's network, including parents, wider family, peers, educators, and other professionals (ASHA, 2016). Attending to more subtle indicators of assent or dissent, such as active participation, avoidance, or resistance during activities, may also provide valuable insight into the child's preferences (Lambert & Glacken, 2011). For other children, alternative approaches to supporting engagement may be more appropriate, such as embedding therapeutic targets within enjoyable activities or daily routines, an area explored further under Key Finding 4.

Figure 9.1 Example of a Potential Home Practice Agreement

Home Practice Agreement for

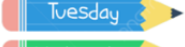
John

My role: to practice my 'snake sound' at home.	Parent's role: to remind me to do my practice	SLT role: to give me words to practice and explain how to do it
--	---	---

Activities I might like...

☒ practice when playing games	
☐ worksheets	
☒ practice in the car	
☐ find words in books I like	
☐ I have a better idea... _____	

days I have time to do home practice:

☐	 Sunday
☒	 Monday
☐	 Tuesday
☐	 Wednesday
☒	 Thursday
☐	 Friday
☒	 Saturday

I like...

playing snakes and ladders
drawing
hurling

time I will spend...



5

_____ minutes

9.5 Key Finding 3: Sustaining Motivation and Perseverance in Home Practice

9.5.1 A Look Under the Self-Determination Theory

Sometimes even when a child understands the purpose of home practice, knows their goals, and wants to change, completing home practice can still be challenging. As Randall aptly described, regardless of the activity or timing of home practice, sometimes “you just don’t want to work on anything”. Children’s insights inspired a deeper look into the factors that promote or hinder motivation. Upon review of the theories of change discussed in the literature review, the Self-Determination Theory (SDT) appeared most relevant and aligned to the findings presented in this study (Deci & Ryan, 1985). This theory explains that there are three fundamental psychological needs which need to be met in order to increase motivation. The first is autonomy, meaning that a person must feel that it is their decision if and how to carry out the task. The second is competence, meaning that feeling capable of achieving desired outcomes is essential for having the motivation to start. Relatedness and a sense of belonging is the third factor, as a person is often motivated to behave in certain ways because the behaviours were prompted, modelled or valued by others in their life (Deci & Ryan, 2008). Within SDT, motivation is also understood to exist along a continuum, ranging from externally regulated behaviour, driven by rewards, pressure, or compliance, to more intrinsically motivated engagement, where activities are experienced as enjoyable or personally meaningful. Movement along this continuum depends on how the three psychological needs are supported (Haerens et al., 2021). The insights provided by children and discussion on how to foster motivation for home practice engagement will be discussed under the context of these needs below.

9.5.2 Autonomy

Autonomy is an important concept in many healthcare models such as family-centred practice (Dunst, 2002), neurodiversity affirming care (Gaddy & Crow, 2023), and the biopsychosocial model (Threats, 2008). It is widely known that patients have autonomy to make their own informed decisions about their healthcare, however autonomy becomes more complex when parents/guardians are

required to make decisions on their child's behalf (Coyne et al., 2014). The SR revealed that children's autonomy can either be compromised or respected from as early as the decision to attend intervention (Fourie et al., 2011; Hearne et al., 2008). The decision to uproot routines to attend therapy and complete home practice was tumultuous for many children who discussed not wanting to miss out on school activities and not having as much time for hobbies and rest for example (Alighieri et al., 2023; Hearne et al., 2008; Van Poucke et al., 2025). Adolescents who stutter appeared to have more autonomy in terms of attending therapy, as all except one participant reported instigating the process (Hearne et al., 2008). One child with an SSD in Fourie et al.'s (2011) study agreed, however the other participants felt that their participation was "mandatory". Stuttering therapy has a longer history of engaging with psychological and emotional aspects of communication, with interventions often supporting individuals' attitudes and acceptance of their stutter (Leahy, 2005), potentially explaining why children and adolescents appear to experience greater autonomy in decisions about therapy participation. Taking a page from stuttering therapy, meeting the child where they are at in terms of awareness and acceptance and using strategies discussed above could help children feel autonomous over their intervention in these initial stages.

In terms of autonomy in home practice, children valued having choices and being supported to guide their own work. As previously stated, they currently describe being "told" what to do for home practice rather than being included in the design and monitoring processes. Jack was the only participant who described having any type of input into his home practice when he explained that his SLT would make home practice easier when he reported it being too difficult. The SR results suggest that being given choices about what activities and materials used and supported to make decisions is one way children feel would improve their experience (Fourie et al., 2011; Gallagher et al., 2019). Allowing them to be involved in the process of choosing what home practice looks like, whether it is worksheets, games, or strategies, and the timing and quantity of home practice could start with goal-setting process described earlier.

Continuously monitoring home practice would also be useful to reduce pressure of initial plans working immediately. To ensure monitoring remains autonomous, rather than feeling like homework is being graded or judged, child-centred measures could encourage reflection instead of solely evaluating their skills. For example, visual scales could be used to understand how challenging or fun children found home practice, similar to those used in the CIS (See Figure 7.2). Currently, monitoring home practice is generally reduced to a quick “check in” at the start of the session (Doherty et al., 2025; Table 8.1), and more emphasis is placed on measuring child outcomes over time. There is growing understanding that outcome measuring should extend beyond impairment reduction to include participation and well-being, and tools have been developed to help clinicians collect and track this data (e.g., John, 2011; Markham et al., 2011). However, research has not delved into how outcome measuring can be meaningfully linked to home practice experiences, and the impact of home practice on these outcomes. Perhaps more exploration is needed into measuring families’ confidence practising strategies or children’s engagement and enjoyment of home practice.

9.5.3 Competence

Children’s beliefs of their own capability to complete activities also impacted how they engaged with them. Many children (including Kevin and Randall) felt that they did not have the time to complete all of their home practice (Braden et al., 2018; Hearne et al., 2008). Additionally, the widespread dislike of home practice appeared to make motivation and engagement even more challenging. Perceiving home practice as unrealistic or unpleasant may undermine children’s sense of competence, leading to avoidance or resistance to attempting the activities. Children also had varying views on how the difficulty of an activity itself impacts desire to complete it. Many children, including Jack, appeared aware that therapy activities needed to have a certain element of challenge in order to learn new things and develop skills (Alighieri et al., 2023; Caughter & Dunsmuir, 2017; Gallagher et al., 2019). On the other hand very difficult activities led to children not enjoying therapy, or being too afraid to try the exercises (Alighieri et al., 2023; Van Poucke et

al., 2025). Similarly children who reported home practice being easier generally reported finding it more enjoyable. Therefore, it is important to personalise activities and home practice to be in line with their current skills, which is also already widely recommended across literature (ASHA, 2016).

Such guidance on personalising intervention is largely grounded in identifying the optimal conditions for learning, such as working within the learner's zone of proximal development (Vygotsky, 1978), where tasks are challenging yet achievable with appropriate support. However, the countless reports of children still finding home practice challenging and overwhelming suggest that this approach may not always translate effectively to home practice and indicates the need to look at other ways to boost children's feeling of competence and confidence. Insights from habit-change literature outside the speech and language therapy field further help to contextualise these findings. Across models, there is consistent emphasis on reducing effort and increasing feasibility when motivation is low. For example, Fogg's Behaviour Model proposes that behaviour change is most likely when tasks are easy to perform (Duarte-Anselmi et al., 2025). Complementing this model, habit-formation research suggests that starting with small, achievable actions can help reduce effort and cognitive demand, making behaviours easier to repeat and more likely to become established over time. Repetition within stable routines combined with early experiences of success supports the development of positive associations and reduces the conscious effort needed to complete tasks (Buabang et al., 2025).

Taking from these models, perhaps home practice would be more effective if introduced gradually, rather than aiming for ideal dosage from the beginning. Starting with short, achievable, and fun activities as brief as a few minutes may support children's confidence and positive association with home practice. Initial home practice could also build an interest in communication which would be helpful for sustaining motivation over time, such as finding books they enjoy, creating materials based on favourite characters, or practising communication during their favourite games and hobbies. Alternatively, children themselves suggested integrating practice into everyday routines rather than feeling like home

practice is an additional task (Braden et al., 2018; Hearne et al., 2008). For example, Randall reported enjoying his casual practice in the car more than his structured activities and his parent also reported more success that way. Although specific strategies may vary, children's accounts indicate that perceiving home practice as achievable and feeling competent is essential to sustaining engagement.

9.5.4 Relatedness

Habit-change theories such as those described above are often criticised for not taking into account other social, relational, and contextual factors which influence motivation (Segar, 2022). In SDT, relatedness is the third essential psychological need which needs to be met to promote engagement and motivation (Deci & Ryan, 2008). Haerens et al. (2021) suggest that children are more likely to engage in activities when they perceive that the adults around them value their participation, model engagement themselves, and provide encouragement within supportive relationships. Within the SR and CIS, children consistently emphasised the importance of relationships in shaping their experiences of speech and language therapy, suggesting that relatedness plays a key role in how children engage with activities and home practice.

Firstly, children valued their relationship with their SLT. Similarities emerged from both studies, as across both children valued clinicians who were knowledgeable, approachable, kind, and able to share information in an accessible way (Braden et al., 2018; Caughter & Dunsmuir, 2017; Fourie et al., 2011). Children's emphasis on the therapist's expertise may also relate to feelings of competence, as believing that the therapist "knows everything I needed" (Jack) appeared to foster confidence that change was possible. Trust also appeared to be a central part of a positive therapeutic alliance, whether through trusting that the therapist could help them achieve their goals, as described by Jack, or trusting that they would listen to their concerns and maintain confidentiality (Braden et al., 2018; Caughter & Dunsmuir, 2017; Fourie et al., 2011). On the contrary, distrust led to disengagement and dislike of therapy (Fourie et al., 2011). Research on therapeutic alliance and common factors theory similarly highlights clinician qualities such as empathy,

flexibility, patience, and confidence as central to engagement and positive outcomes (Byrne & Connery, 2023; Ebert & Kohnert, 2010; Fourie, 2009). Actively creating opportunities for children to discuss their concerns, preferences, and ideas for change in an empathetic manner may therefore be particularly important for supporting engagement beyond the therapy session.

Children's experiences of relatedness also extended to teachers and peers. The SR identified teacher support as beneficial for helping children remember and apply strategies in school settings, particularly when SLTs shared the child's goals and strategies (Braden et al., 2018; Caughter & Dunsmuir, 2017; Van Poucke et al., 2025). The importance of SLT and teacher collaboration has been well documented, for example to share knowledge and skills between professionals, provide consistency for the child, and ensure approaches used compliment the child's needs and goals (Glover et al., 2015). However from a motivational perspective, teacher involvement may also influence how safe children feel to practice and how worthwhile children perceive the use of their home practice. When teachers are engaged and understanding, children may feel more confident and motivated to practice new skills or strategies in the classroom. Additionally, some children such as Nick and Randall and those in Hearne et al.'s (2008) study reported reluctance to attempt strategies in front of peers or disclose their therapy attendance with friends (Alighieri et al., 2023; Van Poucke et al., 2025), reflecting concerns related to stigma and fear of judgement (Lyons & Roulstone, 2017). Collaboration between SLTs and teachers could extend beyond direct support for the child with SLCN, to also include raising awareness across the peer group of communication differences, promoting acceptance of differences from an early age, and fostering a culture of support within educational settings. Many barriers to this interprofessional collaboration exist, such as time constraints, role ambiguity, and limited training, which need to be addressed to extend teachers' roles in SLCN support (Mccartney, 1999). However the key role teachers play in sustaining motivation highlighted this as an important area for development.

Peer relationships influenced children's motivation and engagement differently depending on context. In group-based intervention, many participants

reported that working alongside peers with similar experiences reduced feelings of isolation and normalised their difficulties (Caughter & Dunsmuir, 2017; Hearne et al., 2008). In contrast, classroom contexts may heighten concerns about being different or singled out (Lyons & Roulstone, 2018; Roulstone et al., 2012b). Peer relatedness is evidently most beneficial when children feel safe and supported, perhaps highlighting the need to facilitate more peer connections. Providing opportunities children with SLCN to connect with others with similar difficulties, either in group intervention, or in less formal social groups or online formats, could be beneficial to foster motivation and confidence for some children with SLCN, and show them that they are not alone.

Finally, family support was mentioned in both studies. Parents reportedly played a practical role in supporting home practice such as giving children reminders, explaining what to do, and supporting completion (Braden et al., 2018; Hearne et al., 2008)(also reported by Jack, Kevin, Nick, and Randall). Parents also played a key role in supporting adolescents who stutter to accept their communication differences in one study (Caughter & Dunsmuir, 2017). However, parents frequently report difficulties sustaining both their own motivation and their child's engagement with home practice, particularly when children resist participation (Sugden et al., 2019). Other than in Caughter and Dunsmuir's (2017) study, parents role in home practice is seemingly enforcement-based rather than enjoyable for both sides. Additionally, no other family members were discussed by participants in either study, suggesting that responsibility for home practice is largely placed on parents alone. Better support for parents in facilitating home practice that supports their relationship with their child and helps to sustain engagement from themselves and the child is warranted (further discussion on this concept in Key Finding 5).

9.5.5 Summary of Key Finding 3

Findings from both studies indicate that children's motivation to engage in therapy and home practice is influenced by how their core psychological needs of relatedness, autonomy, and competence are met across therapy, family, school,

and peer contexts. When children felt supported and understood, involved in decisions, and capable of succeeding at tasks, they appeared more motivated to engage and persist with intervention activities. Conversely, when these needs were undermined through mistrust, limited involvement, fear of failing, or being singled out by others, engagement was reduced. From a self-determination perspective, supporting all three needs is likely going to facilitate movement along the intrinsic–extrinsic motivation continuum towards more self-determined and autonomous forms of engagement (Deci & Ryan, 2008; Haerens et al., 2021). However, intrinsically regulated motivation only occurs when the child genuinely enjoys the actions and activities, leading to the next key finding which explores the role of fun and play in home practice.

9.6 Key Finding 4: Importance of Fun and Games in Home Practice

9.6.1 *Enjoyment of Intervention and Home Practice*

A common finding across both the SR and CIS was the strong emphasis children placed on the element of fun, both within therapy sessions and during home practice. The finding that nearly half of the studies in the SR reported children discussing fun and games highlights its significance. Both studies also revealed considerable variation in children’s perceptions of how much they enjoyed therapy. Some interview participants expressed excitement and anticipation about attending therapy (Beth and Kevin), while the rest felt indifferent. Similarly, while some participants in the SR enjoyed intervention, others described it as “boring” and “dull”. Children also emphasised that fun and games are important regardless of the intervention format. For example a critique raised by children in Dematagoda and Sutherland’s (2022) study was that teletherapy did not have as many games compared to in-person intervention. On the other hand Beth, who completed most of her therapy online, appeared to feel that the online games and tech novelties of the videocall platform were the best part of her intervention. The importance of fun extended to home practice as well, with children’s experiences ranging from enjoyment, with Beth explaining that “it’s fun to try new things”, to extreme dislike, as Kevin described it as “torture”. These findings suggest that while therapy and

home practice is not universally enjoyed, fun is consistently valued by children, either as something they experience or as something they wish was present.

9.6.2 Learning Through Play

This focus on fun aligns with several theories of child development which state that children develop cognitive, social, language, physical, and problem-solving skills through play (Piaget, 1962; Vygotsky, 1967; Zosh et al., 2017). Play can be a difficult concept to neatly define, however, Cheep-Aranai et al. (2015) combine descriptions from many sources to summarise play as “an activity that integrates mental and physical activity in a meaningful context characterised by enjoyment, spontaneity, creativity, and an absence of fear and punishment.” (p.142). Children in both studies described play in relation to enjoyment and creativity as per this definition, and depicted different types of play. For example, younger children enjoyed outdoor movement (Harvey & Spencer, 2019), while older children took pleasure in board games (Randall), quizzes (Beth), Pokémon games (Kevin), and singing (Braden et al., 2018). However, the way games were utilised according to children’s accounts sometimes differed from the play-based studies in education and speech and language therapy.

Brackenbury & Kopf (2022) explain that SLTs use games in two distinct ways; either as an integral part of the therapy, or as a reward for completing another non-play-based task. The former method has been proven effective for teaching and learning across many disciplines and domains, including early education settings (Parker et al., 2022), early intervention in speech and language therapy (McLeod et al., 2017), and social communication goals for autistic children (Gibson et al., 2021; Lindsay et al., 2017). The adolescent in Braden et al.’s study (2018) who engaged in singing as part of voice therapy may be considered this type of playful learning, as the therapy was integrated into an activity they enjoyed. If the child enjoys learning through play, this approach could also be described as intrinsic motivation in SDT (Haerens et al., 2021). In contrast, the use of games as rewards is generally considered an externally regulated extrinsic motivator (Haerens et al., 2021). This approach appeared more common across both studies, as there appeared to be a

separation between the “games” and the “work”. Randall’s intriguing comment that enjoying therapy “depends if it’s fun or if you’re doing work” demonstrates two distinct parts of his session; the language-based tasks, and the games played. Other children also described games as a fun activity they get to do following completion of less enjoyable tasks, such as Beth’s favourite “slime game”. This type of extrinsic motivation may be successful for engaging some children, such as Beth, however generally intrinsic motivation is often considered more sustainable in the long term (Deci & Ryan, 2008). There appears to be an opportunity to more effectively integrate fun and play as central elements of both therapy sessions and home practice.

9.6.3 Gamification

Extending from the literature on play-based literature are the concepts of “serious games” and “gamification”. Gamification is the addition of game characteristics to non-game activities (Brackenbury & Kopf, 2022). This could involve receiving rewards, customisation, using narrative storylines etc (Tang et al., 2019). For example, many SLTs use off-the-shelf board games within sessions and adapt them for therapy purposes, e.g., giving the child a game piece as a reward for correct production of a sound (Springle, 2024). Serious games on the other hand are games specifically designed for learning purposes (Springle, 2024). Some of the home practice described by participants included gamification and serious game elements. For example, Randall described some of his worksheets as “worksheets but they’re games”. Although he found it difficult to describe what these worksheets looked like, paper-based activities are often used by SLTs and try to incorporate a game or craft-based elements (Santos et al., 2022). Similarly, in Nick’s interview, his mum helped him describe his home practice as “cut and stick” activities. These activities are specifically designed with a learning goal in mind, and so could be described as a type of “serious game”.

Literature on “serious games” has recently shifted toward development of digital and online games, rather than the traditional paper based or board game formats (Hajesmaeel-Gohari et al., 2023; Tang et al., 2019), a trend mirrored by suggestions from Kevin and Randall. For example, Kevin recommended using

Artificial Intelligence such as ChatGPT to make home practice more interesting. He suggested asking it “how to pronounce [words]”, highlighting numerous potential functions such as providing instructions, audio feedback, and a practice partner. Randall’s suggestion involved watching YouTube videos to learn new vocabulary. Undoubtedly, unsupervised learning through AI and passively watching online content poses many risks unknown to children, such as AI providing unreliable information, safety concerns about advice it gives, and the addictive nature of social media platforms (Kim et al., 2024; UNICEF, n.d.). Additionally, although Randall reported learning just as many new words from watching YouTube as he did from his SLT home practice, another study showed that popular children’s books had greater vocabulary size and lexical diversity than popular YouTube videos for children (Kim, 2025). Nevertheless, it is important to incorporate children’s interests and passions into therapy, and technology is ever increasing in popularity among children and young people (Szymkowiak et al., 2021). Therefore, ensuring that artificial intelligence, social media, and apps are used appropriately to foster the child’s engagement and promote learning is vital.

9.6.4 What Could “Fun” Home Practice Look Like?

Drawing from Kevin and Randall’s suggestions, further development and use of digital serious games could be one solution to incorporating more fun and games into therapy and home practice. Further development of serious games should incorporate guidelines such as those provided by Zaki et al. (2017) and ensure to include children with SLCN in their design and research process. SLTs may encounter challenges using these serious games such as the associated cost, lack of access to technology, and lack of awareness of games that exist and their effectiveness (Springle, 2024). Providing opportunities to learn about evidence-based serious games through continuous professional development events and having budget allowance for technology and appropriate apps could support their use. While most participants agreed that use of apps and online games would be interesting home practice, it was not the only aspect they felt would make home practice “fun”.

As mentioned earlier, personalising and incorporating the child's interests is an essential part of making home practice fun and engaging. One method of customising home practice is to adjust the level of difficulty (explored more in Key Finding 3- Competence). Beth and Kevin also emphasised how interacting with their interests like quizzes and Pokémon was important to them. In order to understand the child's interests, the therapist must spend time building rapport and getting to know their likes and preferences, again emphasising the need to spend time building positive therapeutic alliance. Customisation can also take time to plan and organise for each individual child, which is already a scarce resources for many SLTs (O'Connor & Pettigrew, 2009; O'Toole et al., 2025). Addressing these constraints may require changes at a service level that recognise planning, preparation, and resource development as essential parts of effective intervention, rather than optional extras. Increasing access to support roles like speech and language therapy assistants may also help create more engaging and personalised home practice (McCartney et al., 2005).

The concept of fun and games also adapts as children become older and interests evolve. For example the children in Fourie et al.'s (2011) study played less games as they got older, and the oldest participant in the CIS, Jack, reported that games were not a big part of his intervention. Perhaps children feel less need for fun in learning as they get older, as Jack felt that play-based home practice would have been less effective than the written assignments he received. Although he appeared content with his work, the unbalanced dislike of home practice suggests that other older children and adolescents would benefit from addition of activities they would consider fun. Rice (2009) argues playful learning can even be adapted for adults and has improved creativity, knowledge, and educational outcomes of some university students. Addition of different "fun" elements for older children and adolescents could include creative activities, involving peers and social interactions/games, or gamification techniques like earning points, practice "streaks", or weekly challenges.

There is clear value in making therapy more enjoyable, and alongside the motivational factors discussed earlier, the inclusion of fun could enhance children's

experiences of home practice. However, improving home practice also relies on the wider context and the individuals involved in supporting the child.

9.7 Key finding 5: Parent Support is Needed for Children's Success

9.7.1 Parents Need Support

Across several findings already discussed, there is a repeated theme of a need for supporting parents with home practice. Firstly, children described parent involvement in a practical sense such as bringing them to sessions, reminding them to complete home practice, and explaining activities when unsure. Reliance on parent involvement is further reinforced by service-level challenges, where home practice is frequently used as a pragmatic means of increasing dosage in under-resourced services (Doherty et al., 2025; O'Shea et al., 2024; Sims, 2015; Sugden et al., 2019). Secondly, the combination of children's dislike and parents' challenges supporting home practice often lead to emotional burden and increased feelings of guilt, shame, fatigue (Doherty et al., 2025). Although children in this study did not directly mention this, their strong values of autonomy, competence, and relatedness may cause them to view these challenges as negatively impacting their experiences and relationship with their parent, particularly if parents are seen as enforcing practice rather than supporting it. Lastly, although family-centred practice is valued by SLTs, families, and services, SLTs face practical, educational, or attitude barriers to implementing, leading to more professionally-centred practice than ideal (Biggs et al., 2024). Additionally, some studies have shown that some SLTs have a misguided view that home practice is a way to measure parent's commitment and accountability (Biggs et al., 2024; Doherty et al., 2025), which undermines the values of family-centred care. These findings show that supporting parents to support children at home is essential to increase family-centred practice, improve family's experiences, and get the most out of home practice.

9.7.2 Coaching Model

One approach that may support a more family-centred approach which could help parents feel confident working with their children at home is adopting a coaching model, by moving away from “teaching” parents and toward “coaching” or supporting them. Coaching models are frequently used in early intervention approaches such as Parent-Child Interaction Therapy (Klatte et al., 2019; O'Toole et al., 2021). While long term goals remain centred around supporting children's communication development, short term goals focus on building parents interaction skills using feedback, reflection, and collaborative problem-solving (Ward et al., 2020). Based on adult learning principles, coaching models are often based on Dunst & Trivette's (2012) six principles, where the clinician must (1) introduce new material, knowledge, or skills (2) provide a demonstration of the skill and illustrate the benefits, (3) provide opportunity to practice, (4) support learning and evaluation, (5) promote reflection and self-assessment, and finally (6) support mastery of the new knowledge or skill. Though further research is needed into which particular characteristics of coaching are effective in speech and language therapy, the benefits have been documented for young children (Ward et al., 2020). However, the approach is less researched for older client groups. Using suggestions from children, and previous literature, examples of how to use coaching strategy with an older client base is described in table 9.1.

Table 9.1 *Ways to Implement a Coaching Approach, in line with Dunst & Trivette (2012)*

Coaching Principle	How SLTs may incorporate coaching
1. Introduce new material, knowledge, or skills	• Explain therapy goals and home practice rationale to both child and family • Include both the child and parent in discussions to explain why an activity matters (e.g., generalisation, confidence, independence) • Link tasks to the child's own goals and interests to support autonomy and relevance.
2. Demonstrate the skill and illustrate its benefits	• Model intervention strategies with the child while the parent observes • Explain clinical reasoning for activities and approaches • Show how skills can be embedded into everyday routines (e.g., car journeys, play, mealtimes)
3. Provide opportunities for guided practice	• Invite parents to practice strategies with their child during sessions while the SLT scaffolds and offers feedback • Gradually introduce strategies/activities to avoid overwhelm and ensure feelings of success • Encourage child participation in deciding how practice happens (e.g., choosing materials) to support autonomy.
4. Support learning and evaluation	• Discuss and decide together on achievable home practice to try at home without the SLT • Frame home practice as trial and error (e.g., "Let's see what works this week").
5. Promote reflection and self-assessment	• Monitor home practice using checklists, scales, or discussion to find out what was easy, difficult, enjoyable etc. • Elicit the child's perspective, as children may notice different challenges or successes than adults. • Support parents to reflect on their experiences • Use the reflection to adapt tasks and problem-solve challenges together
6. Support mastery of new knowledge or skills	• Gradually reduce SLT input as parents gain confidence and skills, while remaining available for problem-solving. • Monitor both the child's progress toward goals, and also parent and child feelings and confidence completing home practice • Where appropriate, shift responsibility increasingly to the child (particularly for older children and adolescents), supporting self-management and autonomy.

9.7.3 Service Models for Coaching

At a service level, greater integration of coaching approaches may require adjustments to delivery models that focus on direct intervention alone. For example, early sessions could place increased emphasis on shared goal-setting, explanation of strategies, and joint practice with families in a similar style to direct intervention. However, as families gain confidence and competence, sessions could then become shorter and more focused on feedback, adaptation, and collaborative problem-solving around home practice challenges. Although this approach may reduce direct time with children, it could potentially increase families' ability to support practice at home, apply strategies in meaningful environments, and support self-management in the long term, particularly for children with long-term difficulties (Panagioti et al., 2014). Given that many families already report feeling unsupported in services (O'Shea et al., 2024), supporting self-management in this way may improve rather than reduce services.

However, this approach will not be suitable for all children with SLCN. For example, some children with SSDs may benefit most from specialised direct intervention, where difficulties can be resolved more efficiently through intensive therapist-led intervention (Allen, 2013; Baker, 2012). Similarly, some children such as older adolescents may prefer more independent engagement with therapy and home practice and have less parental involvement. Implementing a coaching model would require further research into how effectively it could support children's goals and if it would alter families' satisfaction with services.

9.7.4 Wider Support Network

It is also important to acknowledge that while the core focus of family involvement is typically placed on parents, another potential way of supporting families is by drawing on the child's wider support network when possible. To date, minimal research has examined the involvement of extended family members in speech and language therapy. However, some studies suggest potential benefits of including extended family such as grandparents, siblings, and aunts and uncles (Lynam, 2024; Mandak et al., 2017). Broadening responsibility beyond parents alone

may help reduce pressure and emotional burden, increase opportunities for practice across contexts, and provide children with more varied communication partners.

9.8 Chapter 9 Summary

Overall, the five key findings highlight that children's experiences of speech and language therapy and home practice are influenced by their motivation, relationships, service structures, and how much their perspectives are acknowledged. Across both studies, children demonstrated that engagement cannot be reduced to simply completing homework activities, but instead depends on feeling understood, involved, and supported within meaningful contexts. While home practice holds clear potential to increase dosage, promote generalisation, and support self-management, current approaches do not always reflect these broader aims. The findings therefore point toward a need to reconsider how home practice is conceptualised and supported within services. These interpretations must be considered in light of the methodological limitations of the current study, which is discussed in the following chapter before outlining implications for research, practice, and service design.

Chapter 10: Limitations and Future Directions

10.1 Critiques of the Current Study

Several limitations of the CIS should be acknowledged. Despite efforts across multiple channels to recruit participants for the study, recruitment was challenging, and a convenience sampling approach was used to enable access to children and families within the available timeframe. While this approach was pragmatic and appropriate given the challenges of recruiting children with SLCN, selecting participants based on accessibility and availability may have influenced the perspectives represented within the sample. For example, children and families who were more willing to participate or who had particularly positive or negative experiences with home practice may have been more likely to take part, which could have shaped the experiences captured within the findings (Drotar & Reikert, 2000). Additionally, while the sample included a range of client types, other groups of children with SLCN were not represented such as children who stutter or AAC users. However, the participants provided varying opinions and views, and while not generalisable to other contexts, cultural backgrounds, or communication profiles, their insights provided diverse and interesting viewpoints.

A second limitation is the absence of formal PPI in the study design. PPI would have further strengthened the study by informing the research questions, materials, and methods to better reflect children's priorities and lived experiences.

Thirdly, although steps were taken to provide accessible and flexible communication methods, children may have had difficulties articulating abstract reflections or expressing their full opinions due to expressive language difficulties. As a result, accounts of their experiences may have been partial or simplified. Additionally, participants may have felt pressure to provide responses they perceived as expected, due to the power imbalance between adult research and child participant. A further limitation was that member checking was not conducted, meaning children did not have the opportunity to review and clarify the researcher's interpretations of their accounts. Other efforts were made to mitigate these

challenges by using inclusive methods, reflexive practice, and placing strong emphasis on assent and autonomy, however these dynamics should be considered when interpreting the findings.

The SR also had limitations. The restriction to peer-reviewed, English-language studies may have introduced a publication and language bias (Paez, 2017), limiting inclusion of research from multilingual contexts. Furthermore, all included studies were conducted in high-income Western countries, reducing cultural generalisability of the findings. In terms of methodological limitations, not all articles were independently screened by two reviewers. However, the research supervisor's review of a sample of papers helped refine inclusion criteria and reduce the risk of excluding relevant studies. Finally, while systematic methods were applied, narrative synthesis involves researcher interpretation and may introduce some subjectivity.

10.2 Implications for Practice and Research

To synthesise the implications identified within the key findings presented in Chapter 9, figure 10.1 presents a visual representation of how we can listen to children's voices and implement child-centred changes across a range of systems. This layered approach highlights how children's perspectives can be valued not only within individual therapy sessions, but also by the broader systems that influence whether their voices are heard and acted upon.

10.2.1 At the Session Level

We have previously established several key factors that children identified as promoters or barriers of child-centred and enjoyable therapy, such as being included in goal-setting agreements, the importance of fun, and the need for autonomy, competence, and support from others. These findings indicate that engagement is influenced by both the child's willingness to complete tasks and the way therapy is structured, explained, and experienced from the initial sessions. At the session level, small changes to practice may have a meaningful impact on

children's experiences. For example, ensuring that children understand the purpose of therapy, involving them in decisions about activities, and creating opportunities for them to express both positive and negative views. It is also important to ensure practice is relevant and fits into the family's daily life. To summarise these considerations, Table 10.1 provides a checklist of factors that may support more child-centred home practice. It is acknowledged that further research is needed to explore each aspect in depth, and that SLTs may require additional training and systemic support to implement these changes within current service constraints.

Figure 10.1 *Levels at Which We Can Support Children's Perspectives*

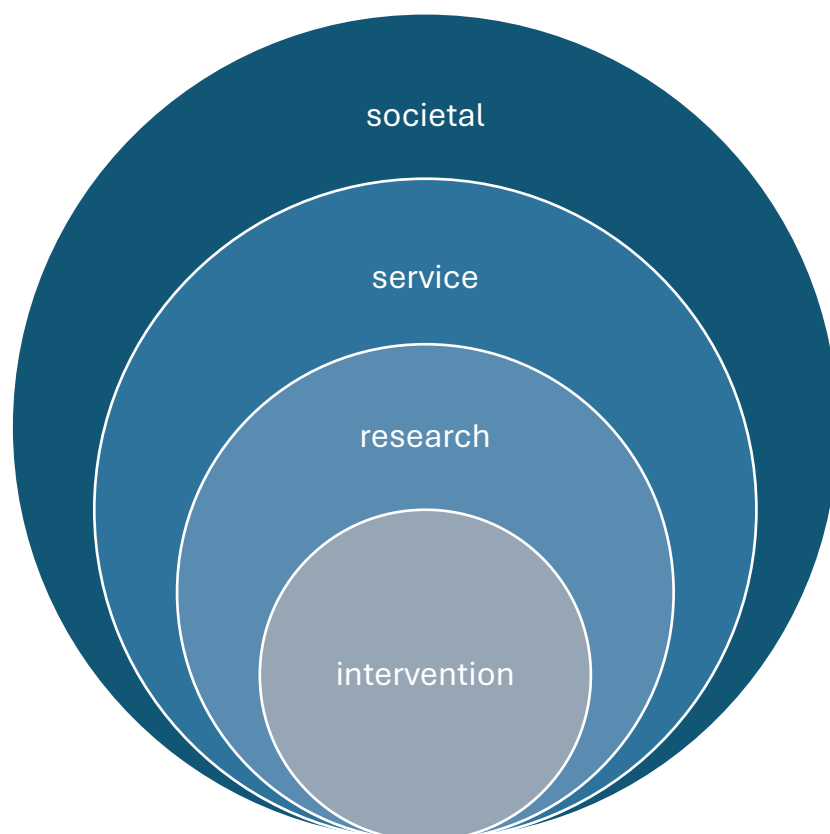


Table 10.1 *Checklist for Child-Centred Home Practice*

Checklist	✓
GOALS	
Have I explained the purpose of assessment and therapy?	
Are the child's goals in line with the preferences and needs expressed by the child and family?	
Does the child understand their goals?	
Have I explored the child's readiness for change? (e.g., discussed challenges, asked if they want to see changes and in what areas, noticed resistance to attendance)	
SESSIONS	
Was the child offered choices?	
How was fun integrated? Rewards or integrated?	
Has the therapeutic relationship been prioritised?	
SETTING HOME PRACTICE	
Does the child know why home practice is necessary?	
Has home practice been designed together? (e.g., giving options on activity, quantity, timing)	
Does the practice incorporate their interests?	
Will the practice easily integrate into their current routines?	
Does the activity work toward a meaningful goal?	
Is the home practice achievable and will the task incite feeling of success and positivity?	
Have I explained the task well and provided instruction in a way they will understand and remember?	
Would a written/visual agreement help guide the conversation?	
MONITORING HOME PRACTICE	
Has the child been given an opportunity to share their experiences?	
Have I created a safe space to share negative experiences?	
Has the child been supported to reflect on any changes they have noticed (or not noticed)?	
Have I used any visual support or checklist to support monitoring the child's feelings, satisfaction, and communication outcomes?	
SUPPORT SYSTEM	
Does the parent understand and agree with the home practice?	
Has the parent been supported to understand the child's perspective on therapy and practice?	
Have I thoroughly explained how to support practice at home?	
Have I offered opportunity for the parent to practice supporting practice with my support in the session?	
Can other family members/professionals be involved to support the child?	
Are expectations of the child and family realistic given their current circumstances?	

10.2.2 At a Research Level

Considering research implications, firstly this study has demonstrated the benefits of using a flexible and inclusive methodology such as the Mosaic approach (Clark, 2017) to elicit views on complex topics from children with SLCN. Continuing to use these methods, other methods discussed in the SR, and other techniques such as photography, diaries, or ranking exercises (Fargas-Malet et al., 2010) may help grow and strengthen further research. Accessible methods are also important in terms of explaining research and obtaining assent from children. While the use of adapted assent strategies, such as those described by Lambert and Glacken (2001), is essential, transparent reporting of these processes is equally important to demonstrate trustworthiness, ensure ethical accountability, and facilitate knowledge sharing within the research community.

In terms of directions for further research, this study shows that children's views on service delivery has been generally quite broad, and more attention is needed on specific areas which arose in the results. For example, exploring specific considerations or tools for involving children in goal setting, monitoring change, giving feedback about therapy, and their views role of family, peers, and other professionals in supporting intervention. Drawing from the earlier reflection in Chapter 8 that SLTs are in an ideal position to facilitate accessible communication in research, SLTs could also play a bigger role in childhood research more broadly, by consulting with researchers from other fields to help children with SLCN participate in a wider array of topics that affect them.

Beyond data collection methods, children's involvement in research design and dissemination warrants attention. Although meaningful PPI presents with practical challenges such as the recruitment difficulties faced in this study, it's absence risks perpetuating adults' assumptions about children's perspectives. Including children in developing research questions, study design, and providing feedback on results are some ways to include families in research design that uphold children's right to express their views and lead to enhanced research impact (Molloy et al., 2019). Approaches to support effective research dissemination to children include consulting participants throughout the process, using flexible and

engaging formats such as visuals, videos, and social media, seeking specialist design expertise where appropriate, and using positive language that avoids stigma and stereotypes (Egli et al., 2019).

10.2.3 At a Service Level

It is important to recognise that service design is a complex process that must account for multiple perspectives, including professionals, service users, and wider organisational and economic considerations. However, including children's voices in service design and policy development should not be overlooked, as it ensures their voices are heard (Lundy, 2007), their rights are upheld (United Nations, 1989), and could potentially lead to uptake and increased confidence in services (Bird et al., 2013). Firstly, service design should be rooted in a strong evidence base. While further research of children's views of service design and delivery is needed, the existing and growing body of literature should already be used to inform service planning. Additionally, several potential directions for service delivery change emerged throughout this discussion, such as increasing access to speech and language therapy assistant roles or reorienting time spent on direct intervention with the child to focus more on coaching, mentoring, and supporting self-management. That being said, children's diverse views on aspects such as mode of delivery, session timing, and ideal setting highlighted the importance of a flexible approach to service delivery, as each child has unique needs and preferences. Given the challenges of implementing flexible service models, perhaps employing both family- and child-reported feedback on service satisfaction could help to better understand families' experiences and identify areas where changes could lead to improvement. Adapting these measures to be accessible for children with SLCN would be essential, and could be developed in consultation with SLTs.

10.2.4 At a Societal Level

At a broader societal level, the findings of this thesis challenge perceptions of children as passive recipients of care. At the very least, children's perspectives

showed that fear of judgement and stigma associated with having SLCN can negatively impact their ability to practice strategies and home practice with peers and in the classroom (e.g., Van Poucke et al. 2025 and Alighieri et al., 2023). Looking more broadly, limited understanding of SLCN and how to include children with disabilities may be reducing opportunities for children with SLCN to make their own decisions, participate in research, policy development, and share their views (Njelesani et al., 2022). Increasing public awareness of communication accessibility and children's rights is therefore a critical component of supporting children's voices. A good first step is increasing inclusion in research using methods explained above. It is also important to share this research in accessible formats to expand reach beyond the research community and to the public. Campaigns such as the International Communication Project were successful in raising awareness of communication disability and successfully advocating for communication to be viewed as a human right (Mulcair et al., 2018). Perhaps further efforts could focus on promoting this awareness among children and young people, to support acceptance of communication differences from an early age. SLTs have a potential role in advocacy work at this level. For example, as previously mentioned, working with education system and teachers to develop learning outcomes or programmes to foster inclusive attitudes and support children with SLCN to feel confident and accepted. These findings highlight that supporting children's voices requires not only changes within therapy and services, but broader societal efforts to reduce stigma, promote communication accessibility, and create environments in which children with SLCN feel confident to participate.

10.3 Conclusion

This thesis set out to explore children's views of speech and language therapy service delivery and home practice to address a recognised gap in the field where children's voices have been underrepresented. The findings of both the SR and CIS have demonstrated that children hold meaningful, nuanced, and diverse views of

their therapy experiences, including how therapy is delivered, how goals are set, and how home practice fits into their everyday lives. Importantly, the findings show that when children are adequately supported through accessible and flexible methods, they are capable of clearly expressing these views. While many children discussed their positive experiences of therapy and home practice, this research shows that more needs to be done to include children's voices in decision-making, both within intervention and in wider contexts like research participation and policy development. Continuing to expand the growing evidence-base on children's perspectives would ensure that children's rights to express their views are being upheld.

Key findings have also shown that supporting children's engagement is complex. We must look more broadly than whether children are adhering to activities and complying to adult-initiated approaches. Instead, it is important to acknowledge the various factors which influence children's motivation, including supporting their autonomy, considering readiness to change, pitching home practice at an appropriate level, fostering early experiences of success, and integrating fun, games, and personal interests into therapy. Also highlighted was the importance of the child's wider support network, and the need to provide extra support to families, professionals, and peers to promote an inclusive society in which children with SLCN can participate.

Ultimately, listening to children's perspectives cannot be confined to a single research method, intervention approach, or service delivery structure. Meaningful listening is an achievable process that requires ongoing exploration at the individual, organisational and societal level. Supporting children's views in speech and language therapy has the potential to improve their experiences and outcomes, and also affirm their rights as active contributors to decisions that shape their own lives.

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Appendices

Appendix 1: PRISMA checklist



Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.48
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Attached separately
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Chapter 1-3
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.49
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.50-52
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.53
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.54
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.55
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.55-56
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	N/A
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.56
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.55, p.58
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.56
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	N/A
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.56
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	p.52
Certainty	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	p.55, p.58

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
assessment			
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.57
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	-
Study characteristics	17	Cite each included study and present its characteristics.	p.62
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.60-61
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	-
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	p.60-61
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	p.60-61
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Chapter 9
	23b	Discuss any limitations of the evidence included in the review.	p.80-81
	23c	Discuss any limitations of the review processes used.	p.150
	23d	Discuss implications of the results for practice, policy, and future research.	Chapter 10
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	-
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	-
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	-
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	(none)
Competing interests	26	Declare any competing interests of review authors.	(none)
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	-

Appendix 2: COREQ

Consolidated criteria for reporting qualitative studies 32-item checklist

Developed from:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the inter view or focus group?	(Only one author)
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	p.45 (and implied)
3. Occupation	What was their occupation at the time of the study?	p.45
4. Gender	Was the researcher male or female?	p.45
5. Experience and training	What experience or training did the researcher have?	p.45
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	p.92
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p.96 (reflective log)
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p.45-46
Domain 2: study design		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p.43 and p.84-86
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p.90
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	p.91
12. Sample size	How many participants were in the study?	p.100
13. Non-participation	How many people refused to participate or dropped out? Reasons?	N/A

<i>Setting</i>		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	p.92
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	p.92
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	p.91 and p.X
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p.92-93
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	p.93
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	p.93
20. Field notes	Were field notes made during and/or after the inter view or focus group?	p.96
21. Duration	What was the duration of the interviews or focus group?	p.93
22. Data saturation	Was data saturation discussed?	p.150 (discussed small sample size)
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	p.96
25. Description of the coding tree	Did authors provide a description of the coding tree?	p.97
26. Derivation of themes	Were themes identified in advance or derived from the data?	p.97
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	N/A
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Chapter 8
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Chapter 8
31. Clarity of major themes	Were major themes clearly presented in the findings?	Chapter 8 (and figure 8.1)
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Chapter 8 (and figure 8.1)

Appendix 3: Ethical Approval Letter and Amendment Approval



Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Application	Academic Year 2024/25
Applicant Code	MT10
Applicant/Supervisor Name	Jane Sheridan / Dr Yvonne Lynch
Title of Research	Children's Perspectives of Speech and Language Therapy Home Practice
Date of this letter	22.10.24

Dear Jane,

Your amended submission (dated 21/10/24) for ethical approval for the research project above was considered by the Research Ethics Committee, School of Linguistic, Speech and Communication Sciences, Trinity College Dublin and has been approved in full.

Please note:

- (i) On completion of research projects, applicants should complete the *End of Project Report Form* (which can be found at: <https://www.tcd.ie/slscs/research/ethics/>) and submit one electronic copy (to rec_slscs@tcd.ie)
- (ii) The REC requests, in particular, that you attend to your commitments regarding the storage and destruction of data arising from this research, in keeping with REC policy and General Data Protection Regulation (GDPR) guidelines.

We wish you every luck with your research.

Best wishes,

Dr Bronagh Ćatibušić
Chair, Research Ethics Committee
School of Linguistic, Speech and Communication Sciences

Scoil na nEolaíochtaí Teangeolaíochta,
Urlabhra agus Cumarsáide,
Coláiste na Tríonóide,
Baile Átha Cliath 2, Éire

School of Linguistic, Speech &
Communication Sciences,
Trinity College,
Dublin 2, Ireland

T 353 (0)1 896 1560
slscs@tcd.ie
www.tcd.ie/slscs



Trinity College Dublin

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

Application	Academic Year 2024/25
Applicant Code	MT10
Applicant/Supervisor Name	Jane Sheridan / Dr Yvonne Lynch
Title of Research	Children's Perspectives of Speech and Language Therapy Home Practice
Date of this letter	07.02.25

Dear Jane,

Your amended submission (dated 07.02.25) for ethical approval for the research project above was considered by the Research Ethics Committee, School of Linguistic, Speech and Communication Sciences, Trinity College Dublin and has been approved in full.

Please note:

- (i) On completion of research projects, applicants should complete the *End of Project Report Form* (which can be found at: <https://www.tcd.ie/slscs/research/ethics/>) and submit one electronic copy (to rec_slscs@tcd.ie)
- (ii) The REC requests, in particular, that you attend to your commitments regarding the storage and destruction of data arising from this research, in keeping with REC policy and General Data Protection Regulation (GDPR) guidelines.

We wish you every luck with your research.

Best wishes,

Dr Bronagh Ćatibušić

Chair, Research Ethics Committee

School of Linguistic, Speech and Communication Sciences

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Dublin 2, Ireland

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slscs@tcd.ie
www.tcd.ie/slscs

Appendix 4: Parent Consent Forms

Parent/Guardian Consent Form for their Own Participation

STUDY: Children's Views on Speech and Language Therapy Home Practice	
Recruitment Site: Trinity College Dublin	
Principal Investigator Name and Contact details: Jane Sheridan, sheridj2@tcd.ie	
There are two sections in this form. Section 1 contains statements of understanding and asks you to tick each if you understand. Please ask any questions you may have when reading each of the statements. Section 2 asks for your consent to participate in this study. Please select either 'yes' or 'no' to indicate your choice. Thank you for participating. The end of this form is for the researchers to complete.	
1. General Understanding	Tick
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that taking part in this study is entirely voluntary. I understand that not taking part will have no negative impact on me.	
I understand that I can leave this study at any time without giving a reason, without consequences of any kind.	
I understand that I will not be paid for taking part in this study.	
I know how to contact the researcher if I need to.	
By ticking each box above and choosing my options below and signing this document I agree to participate in 'X' study as described in the Participant Information Leaflet.	
2. Consent	

I agree to take part in this research study, having been fully informed of the risks and benefits in the information leaflet provided to me.	Yes No ☐ ☐
I agree to the use of information I provide about myself and my child (including your name, contact details, and information you give about your experience with speech and language therapy home practice) being used by the named researchers as described in the participant information leaflet.	Yes No ☐ ☐

Participant Name (Block Capitals)

Participant Signature

Date

Witness Name (Block Capitals)

Witness Signature

Date

To be completed by the Principal Investigator.

I, the undersigned, have taken the time to fully explain to the above participant's parent/guardian the nature and purpose of this study in a way that they could understand.

I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the participant information leaflet and consent form to the participant with contact details of the study team.

Researcher name _____

Signature _____

Date _____

Parent/Guardian Consent for Child Participation

STUDY: Children's Views on Speech and Language Therapy Home Practice

Recruitment Site: Trinity College Dublin

Principal Investigator Name and Contact details: Jane Sheridan, sheridj2@tcd.ie

There are **two sections** in this form.

Section 1 contains statements of understanding and asks you to tick each if you understand. Please ask any questions you may have when reading each of the statements.

Section 2 asks for your consent for your child to participate in this study. Please select either 'yes' or 'no' to indicate your choice.

Thank you for participating.

The end of this form is for the researchers to complete.

1. General Understanding	Tick
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand providing consent for my child to participate in this study is entirely voluntary. I understand that not taking part will have no negative impact on me or my child.	
I understand that my child can leave this study at any time without giving a reason, without consequences of any kind.	
I understand that my child and I will not be paid for taking part in this study.	
I know how to contact the researcher if I need to.	
By ticking each box above and choosing my options below and signing this document I agree to participate in 'X' study as described in the Participant Information Leaflet.	
2. Consent	
I agree to my child taking part in this research study, having been fully informed of the risks and benefits in the information leaflet provided to me.	Yes No ☐ ☐

I agree to the use of information about my child (including their name, audio/video recordings of an interview, a transcript of the interview, interview materials such as writing/drawing, information provided by me about their communication supports) being used by the named researchers as described in the participant information leaflet.	Yes	No
	☐	☐

Participant Name (Block Capitals)	Participant Signature	Date
-----------------------------------	-----------------------	------

Witness Name (Block Capitals)	Witness Signature	Date
-------------------------------	-------------------	------

To be completed by the Principal Investigator.

I, the undersigned, have taken the time to fully explain to the above participant's parent/guardian the nature and purpose of this study in a way that they could understand.

I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the participant information leaflet and consent form to the participant with contact details of the study team.

Researcher name _____

Signature _____

Date _____

Appendix 5: Child Assent Form

Perspectives of Children on Speech and Language Therapy Homework

Assent Form

		✓ or ✗
I have had this research explained to me		
I understand that I will talk to a researcher about speech and language therapy homework		
I am happy to have the conversation recorded		
I can take a break or stop at any time		
I agree to take part in the project		

Child's name: _____

Researcher name: _____

Researcher signature: _____

Date: _____

CHILDREN'S VIEWS OF SPEECH AND LANGUAGE THERAPY HOMEWORK

Research participants wanted!



What's Involved?

- You child meeting a researcher 1-2 times to talk about how they found SLT home practice.
- We will use methods that are accessible for your child such as talking, drawing, or using pictures

Who can participate?

Your child can participate if they ...

- ☒ Are aged 6-17 years
- ☒ Attended speech and language therapy in the last year
- ☒ Received activities to complete at home

Interested?

Email Jane Sheridan at **sheridj2@tcd.ie** for more info



Trinity
College
Dublin

The University of Dublin

Principle investigator: Jane Sheridan, sheridj2@tcd.ie
Supervisor: Dr Yvonne Lynch, lynchyv@tcd.ie
Ethical approval: granted by Trinity College Dublin

Appendix 7: Gatekeeper Letter

Dear X,

My name is Jane Sheridan, and I am a speech and language therapist currently completing a master's degree in Clinical Speech and Language Studies, Trinity College Dublin. As part of my study, I am undertaking research on children's perspectives of speech and language therapy home practice.

I am writing to ask your permission to act as a gatekeeper to my study. This would involve disseminating flyers for the study (attached) to parents of children attending speech and language therapy. Anyone interested in participating would then contact myself directly. I will outline what is involved in the study below.

What participation involves for children
Participation will involve attending two interviews with myself, the principal researcher. Interviews will use a range of verbal and/or visual techniques, adapted to suit the needs of the child. Assent from the child and informed written parental consent will be required for a child to participate. The interviews will questions will investigate how the child found speech and language therapy home practice, including what they found useful or challenging.
Inclusion Criteria
• Children aged 6-17 (inclusive) • Children who have received speech and language therapy intervention in the previous year for a minimum of 6 weeks • Children who have been assigned home practice as part of intervention. (home practice can include games, worksheets, activities, strategies for the child)
Research Data
Interviews with the child will be audio or video recorded with consent/assent. Data will be stored securely on Trinity College Dublin-issued Microsoft 365 services, under GDPR and Trinity College Dublin guidelines. This study has been ethically approved by Trinity College Dublin.

Thank you for your consideration. Please feel free to contact me or my supervisor with any questions or concerns.

Kind regards,

Jane Sheridan
sheridj2@tcd.ie

(Supervisor: Dr Yvonne Lynch- lynchyv@tcd.ie)

Appendix 8: Participant Information Leaflets for Parents

Participant Information Leaflet: Parent/Guardian Involvement

Study Title	Children's views of Speech and Language Therapy Home Practice
Research Site(s)	Trinity College Dublin, participant's home, or area of convenience. Online interviews (Zoom) may be used if suitable.
Principal Investigator(s) and Co-Investigator(s) (Study Team)	Principal investigator: Jane Sheridan, Master's student in the Department of Clinical Speech and Language Studies, Trinity College Dublin, sheridj2@tcd.ie Supervisor: Yvonne Lynch, Assistant Professor, Clinical Speech & Language Studies, Trinity College, lynchyv@tcd.ie
Data Controller	Trinity College Dublin (research data)
Data Protection Officer (Research Data)	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

Introduction

I would like to invite you to take part in a research study that is being carried out by Jane Sheridan, Clinical Speech and Language Studies master's student in Trinity College Dublin.

Before you decide whether or not you wish to take part, please take time to read this information leaflet carefully. If there is anything which is not clear, or if you would like more information, please ask the researcher. You should understand the benefits and any risks of taking part in this study so that you can make a decision that is right for you and your child.

Please note: there are two information leaflets for you to read. This leaflet outlines what is involved for you. The other leaflet outlines what is involved for your child.

Do I have to take part?

No. You do not have to take part. Participation is voluntary. Even if you decide to take part now, you can still withdraw later without consequences of any kind.

Part 1 - The Study

Why have I been invited to take part?

I am interested in understanding children's views of speech and language therapy home practice, and information is required from parents to be able to fully understand the views of their child. You have been invited to take part in this study because you have a child who has received speech and language therapy homework in the previous year and who is interested in taking part interviews with the researcher. I am hoping to have 15 children and their parents involved in the study.

Why is this study being done?

I am doing this study to understand the views of children about speech and language therapy home practice. This study is part of my master's degree. Children have a right to have their voices considered in matters that affect them. Understanding children's views could help us identify how speech and language therapists can improve how they use home practice to make it more fun and more effective at supporting children to reach their goals.

What does taking part involve for me, the parent/guardian?

If you are interested in taking part, the principal researcher will answer any questions you may have. If you decide to participate, you will be asked to sign two consent forms: one to give permission for your child to take part in one or two interviews with the researcher (preferably two but you may also only give consent for one if you choose), and one to give permission for the researcher to collect information provided by you. Discussion on what would be involved for your child is described in detail on another participant information leaflet. Details about what is involved for you as the parent/guardian is described below.

The researcher will **talk to you over the phone** to discuss three main topics:

1. Ask you some **background information** about your child's speech and language homework, such as what it involved, challenges, and benefits.

2. Ask you about your **child's communication profile** and supports they might need, so that the interviews are accessible and enjoyable for your child.
3. Collect **contact information** such as email address, phone number, and home address so that the interviews can be arranged.

The phone call will last **no longer than 30 minutes**. The researcher will type notes during the conversation. You may request a copy of these notes by emailing the principal investigator.

The interviews with your child will then take place in your home, in Trinity College Dublin, or online if it is appropriate for your child's level of communication (whichever you would prefer). **Please see other participant information leaflet for more information on the interview process.**

What are the possible benefits of taking part?

Taking part in this study may not directly benefit you. However, I hope that this research may help us to understand how to use speech and language therapy home practice more effectively and improve children's experiences.

Are there any possible disadvantages or risks from taking part?

There are minimal risks to taking part in this study. The well-being of participants takes priority over research activities.

If you become **fatigued or upset** by any topics discussed on the phone call, you may stop or take a break at any point. The researcher will discuss this at the beginning of the phone call.

Data breach: all possible measures have been taken to ensure the confidentiality of all data and the risk of a breach of confidentiality is very low. See part 2 for more.

What will happen to the results of the study?

The collective data from this research **will discussed in a research project** as part of the researcher's master's degree. The results of the study may also be presented at conferences, shared at professional development workshops, and published in medical and/or educational journals. You and your child will not be able to be identified in any reports or publications.

Part 2 - Data Protection

What information about me (personal data) will be used for this study

The following information will be collected about you, the parent/guardian:

- Your name
- Phone number
- Email address
- Home address (this information will only be collected if you request the interview to be carried out in your own home)
- Brief information on your experience of speech and language therapy homework (e.g., was it challenging, were you supported, do you think your child enjoyed it)

Please see other participant information leaflet for a list of information collected about your child.

Who will access my personal data?

Only the principal researcher and supervisor will have access to the research data. Your data will not be shared with any other people or organisations.

How is the information kept confidential and secure?

Your name will be replaced with a code (e.g., participant 1) on the contact information and notes about the discussion over phone call. Only the principal investigator and supervisor have the key to match your name with your data.

All digital research data is **held securely** on Microsoft Office 365 platforms issued by Trinity College Dublin. The files restricted to the named researchers only. Paper copies of your consent forms will be stored in a locked cabinet in a locked office in Trinity College Dublin.

The researchers are governed by a professional code of conduct to maintain **confidentiality**. A data protection impact assessment was carried out and the risk identified was low.

How long will my personal data be needed??

Your **consent forms and the notes taken** about your phone call will be kept for a period of **three years after the researcher has finished the degree** for which this study is being carried out. **The key** to identify your data will be deleted **immediately after the degree is finished**. After the specified time, your data will be destroyed securely.

What is the lawful (legal) basis to use my personal data?

We will only use your data for this research study, which we hope will improve how speech and language therapy is delivered (Article 6(1)(e) and 9(2)(j) of the GDPR).

What are my rights under Data Protection law?

You are entitled to:

- object to our use of your personal data or any further use;
- request access to your personal data and receive a copy of it;
- request inaccurate personal data be corrected or deleted;
- request restriction of our use of your personal data ;
- request deletion of your personal data.

By law you can exercise the above rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research. For example, once the data has been analysed collectively you cannot withdraw your responses that analysis.

You can exercise these rights by contacting your study researcher [sheridj2@tcd.ie] or the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: <https://www.tcd.ie/dataprotection/>

Part 3 - Approval, Organising and Funding

Has this study been approved by a research ethics committee?

Yes, this study has been **approved by the Research Ethics Committee** of the School of Linguistic, Speech & Communication Sciences, Trinity College Dublin.

Who is organising and funding this study?

This study is being undertaken by Jane Sheridan as part of her postgraduate studies. It is self-funded.

Will I be paid for taking part?

There is **no payment** for taking part.

Part 4 - Further Information

What happens if I change my mind?

Your participation in this study is **voluntary and you can change your mind** even if the study has started. You do not have to give a reason for changing your mind.

If you would like to withdraw from the study, please contact Jane Sheridan at sheridj2@tcd.ie who can organise this for you.

We will discuss if you are happy for us to continue to use information about you which has already been collected. If you do not consent to your personal data being retained for this study, we will delete any information that could identify you.

Please note that we will not be able to remove data that has already been analysed and is about to be published in reports or publications.

We will not contact you again.

Who should I contact for information or concerns?

If you have any concerns or questions about this research, you can contact:

- **Supervisor:** Dr Yvonne Lynch, Dept of Clinical Speech and Language Studies, 7-9 South Leinster Street, Trinity College, Dublin 2. Email: lynchyv@tcd.ie
- **Data Protection Officer**, Trinity College Dublin: Data Protection Office, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie Website: www.tcd.ie/privacy
- Under GDPR, if you are not satisfied with how your data is being processed, you have the right to lodge a complaint with the **Office of the Data Protection**

Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website:
www.dataprotection.ie

Part 5 - Next Steps

If you wish to participate in this study, please email Jane Sheridan for further details at sheridj2@tcd.ie.

Thanks

Thank you for taking the time to read this Participant Information Leaflet.

You will be given a copy of this Leaflet and the signed Consent Form to keep. Please retain these in case they are needed for future reference.

Participant Information Leaflet: Child Involvement

Study Title	Children's views of Speech and Language Therapy Home Practice
Research Site(s)	Trinity College Dublin, participant's home, or area of convenience. Zoom may be used if suitable.
Principal Investigator(s) and Co-Investigator(s) (Study Team)	Principal investigator: Jane Sheridan, Master's student in the Department of Clinical Speech and Language Studies, Trinity College Dublin, sheridj2@tcd.ie Supervisor: Yvonne Lynch, Assistant Professor, Clinical Speech & Language Studies, Trinity College, lynchyv@tcd.ie
Data Controller	Trinity College Dublin (research data)
Data Protection Officer (Research Data)	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

Introduction

I would like to invite you to take part in a research study that is being carried out by Jane Sheridan, Clinical Speech and Language Studies master's student in Trinity College Dublin.

Before you decide whether or not you wish to take part, please take time to read this information leaflet carefully. If there is anything which is not clear, or if you would like more information, please ask the researcher. You should understand the benefits and any risks of taking part in this study so that you can make a decision that is right for you and your child.

Please note: there are two information leaflets for you to read. This leaflet outlines what is involved for your child. The other leaflet outlines what is involved for your own participation.

Does my child have to take part?

No. Your child does not have to take part. Participation is voluntary. Even if they decide to take part now, they can still withdraw later without consequences of any kind.

Parts of this Document

1. The Study

2. Data Protection
3. Approval, Organising and Funding
4. Further Information
5. Next Steps

Part 1 - The Study

Why has my child been invited to take part?

I am interested in understanding your child's views of speech and language therapy home practice. Your child has been invited to take part in this study because:

- They are aged 6-17 years,
- They have attended speech and language therapy in the last year,
- They were given activities to practice at home by the speech and language therapist

I am hoping to have 15 children and their parents involved in the study.

Why is this study being done?

I am doing this study to understand the views of children about speech and language therapy home practice. This study is part of my master's degree. Children have a right to have their voices considered in matters that affect them. Understanding children's views could help us identify how speech and language therapists can improve how they use home practice to make it more fun and more effective at supporting children to reach their goals.

What does taking part involve for my child?

If your child is interested in taking part, the principal researcher will answer any questions they may have. If they would like to participate, and you agree, you will be given a **consent form** and your child will be given an **assent form** to sign.

Your child will be asked to attend **one or two face-to-face interviews** with the principal researcher (preferably two but you may also give consent for only one if you choose). The **first interview** will help you, your child, and the researcher to get to know each other, how to best communicate, and start a conversation about speech and language therapy home practice. The **second interview** will be to continue the conversation, and allow the researcher to make sure they have understood your child correctly. The interviews will be **audio recorded**. If your child communicates non-verbally, the researcher may ask

permission to also video record the interview to accurately record their responses. Interviews that take place over Zoom will also be audio or video recorded. Children under 12 must have a parent in the interview room with them. Children 12 and older can attend on their own if **both** parent and child agree.

Different techniques will be used depending on what your child prefers, for example, talking, writing, drawing, or using visual supports. **The researcher is a qualified speech and language therapist** who is trained in supporting children with communication difficulties. Photographs will be taken of the writing/drawings completed. Interviews will take **no longer than 60 minutes** and will stop if your child becomes tired or you/your child requests to stop. Interviews can either take place in Trinity College Dublin, or in your home, whichever is most convenient for you.

What are the possible benefits of taking part?

Taking part in this study may not directly benefit your child. However, I hope that this research may help us to understand how to use speech and language therapy home practice more effectively and improve children's experiences.

Are there any possible disadvantages or risks from taking part?

There are minimal risks to taking part in this study. The well-being of participants takes priority over research activities.

If your child becomes **tired**, they may **stop or take a break** at any point. The researcher will discuss this before they begin and will look for signs of fatigue/disinterest throughout the interview

Data breach: all possible measures have been taken to ensure the confidentiality of all data and the risk of a breach of confidentiality is very low. See part 2 for more.

What will happen to the results of the study?

The collective data from this research **will discussed in a research project** as part of the researcher's master's degree. The results of the study may also be presented at conferences, shared at professional development workshops, and published in medical and/or educational journals. You and your child will not be able to be identified in any reports or publications.

Part 2 - Data Protection

What information about my child (personal data) will be used for this study

The following information will be collected about your child:

- Their name
- Audio or video recording
- Transcript of the interview
- Photographs of materials used in the interview (e.g., drawings made by your child)
- Information about your child provided by you over phone call, such as:
 - Child's age
 - Type of activities completed for speech and language therapy
 - Description of the child's communication
 - Supports that will help your child's communication

Please see other participant information leaflet for a list of information collected about you, the parent/guardian.

Who will access my personal data?

Only the principal researcher and supervisor will have access to the research data. Your data will not be shared with any other people or organisations.

How is the information kept confidential and secure?

Your child's name will be replaced with a code (e.g., participant 1) on the contact information and notes about the discussion over phone call. Only the principal investigator and supervisor have the key to match your name with your data.

All digital research data is **held securely** on Microsoft Office 365 platforms issued by Trinity College Dublin. The files restricted to the named researchers only. Paper copies of consent/assent forms will be stored in a locked cabinet in a locked office in Trinity College Dublin.

The researchers are governed by a professional code of conduct to maintain **confidentiality**. A data protection impact assessment was carried out and the risk identified was low.

How long will my child's personal data be needed?

The **audio/video recordings will be deleted immediately after they are transcribed. The key** to identify your child's data will be **deleted immediately after the researcher completes the degree** for which this study is being carried out. **All other data** (consent/assent forms, transcriptions, photographs, information provided by you etc.) will be kept for a period of **three years after the degree is finished**. After the specified time, your child's data will be destroyed securely.

What is the lawful (legal) basis to use my child's personal data?

We ask for your consent for your child to take part in this research project as their parent/guardian. [Article 6 (1) (a) and 9 (2) (a)]. If your child reaches 18 during the study, we will ask for their consent to continued use of any personal data collected.

What are my rights under Data Protection law?

You are entitled to:

- object to our use of your child's personal data or any further use;
- request access to your child's personal data and receive a copy of it;
- request inaccurate personal data be corrected or deleted;
- request restriction of our use of your child's personal data ;
- request deletion of your child's personal data.

By law you can exercise the above rights in relation to your child's personal data, unless the request would make it impossible or very difficult to conduct the research. For example, once the data has been analysed collectively you cannot withdraw your child's responses from that analysis.

You can exercise these rights by contacting the study researcher [sheridj2@tcd.ie] or the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: <https://www.tcd.ie/dataprotection/>

Part 3 - Approval, Organising and Funding

Has this study been approved by a research ethics committee?

Yes, this study has been **approved by the Research Ethics Committee** of the School of Linguistic, Speech & Communication Sciences, Trinity College Dublin.

Who is organising and funding this study?

This study is being done by Jane Sheridan as part of her postgraduate studies. It is self-funded.

Will my child be paid for taking part?

There is **no payment** for taking part.

Part 4 - Further Information

What happens if I/my child changes their mind?

Your child's participation in this study is **voluntary**. **You or your child can change your mind even if the study has started.** You do not have to give a reason for changing your mind.

If you or your child decides to withdraw from the study, please contact Jane Sheridan at sheridj2@tcd.ie who can organise this for you.

We will discuss if you are happy for us to continue to use information about your child which has already been collected. If you do not consent to personal data being retained for this study, we will delete any information that could identify you/your child.

Please note that we will not be able to remove data that has already been analysed and is about to be published in reports or publications.

We will not contact you again.

Who should I contact for information or concerns?

If you have any concerns or questions about this research, you can contact:

- **Supervisor:** Dr Yvonne Lynch, Dept of Clinical Speech and Language Studies, 7-9 South Leinster Street, Trinity College, Dublin 2. Email: lynchyv@tcd.ie
- **Data Protection Officer,** Trinity College Dublin: Data Protection Office, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie
Website: www.tcd.ie/privacy

- Under GDPR, if you are not satisfied with how your data is being processed, you have the right to lodge a complaint with the **Office of the Data Protection Commission**, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie

Part 5 - Next Steps

The researcher will send you a follow-up email in a one week to give you time to consider your participation. If we do not hear back from you, we will not contact you again.

You can email Jane at sheridj2@tcd.ie if you would like more information or if you and your child have decided to participate.

Thanks

Thank you for taking the time to read this Participant Information Leaflet.

You will be given a copy of this Leaflet and the signed Consent Form to keep. Please retain these in case they are needed for future reference.

Appendix 9: Participant Information Leaflet for Children

Children's Views on Speech and Language Therapy Homework

Children's Information Leaflet

We want to know what you think of speech and language therapy home practice.	
If you take part, you will talk to a researcher about what you think of Speech and Language Therapy Homework	
You can talk, write, draw, or communicate in any other way you like.	
The conversation will be audio or video recorded.	

You can take a break or stop at any time.	
You do not have to take part if you don't want to, and you can change your mind later.	
Only the researcher will know your answers came from you.	
After you talk to the researcher, you can ask to look at, change, or delete what they wrote or recorded.	

Appendix 10: Note Taking Template for Parent Phone Calls

Participant code:	
Eligibility	
Child Age	
Did they attend SLT in the previous year for at least 6 weeks?	
Did they receive home practice?	
Home practice	
What clinical area did the home practice target?	
Description of home practice (type of activities)	
What did it involve for you?	
What did it involve for your child?	
How was it given to you/explained?	
Did you understand what to do?	
Did you feel confident supporting your child?	
How did you find the guidance/support from your SLT?	
How often was it completed?	
Did the SLT check in/monitor the home practice? How?	
Did you experience any challenges completing home practice?	
Did you find home practice to be useful	
Do you have any suggestions for how to improve how home practice is used?	
Did you child engage with the activities?	
Do you think they enjoyed it?	
Do you think they found it difficult or easy to complete?	
Communication/accessibility factors	
How would you describe their communication (e.g. mainly verbal, AAC user etc.)	
Do you have any suggestions for me in supporting their communication during an interview?	
Would they be able to participate in drawing/writing?	
Other	
Anything else I should know? (e.g. sensory needs/interests/ additional supports required)	

Appendix 11: Interview Topic Guide

Topic guide

- What did you think of the story
- Why do you think Sarah went to speech and language therapy?
- Tell me a bit about what you did in speech and language therapy- same/different?
 - Did you go once a week?
 - Who brought you?
 - What kinds of things did you do in the sessions?
- How do you feel about going to SLT
 - I look forward to it
 - I dread going
 - In the middle
- Did you get homework? What type? – go through examples
- How often did you do it- All/most/some/never. How often was that- daily/weekly
- Who did you do it with? Parents/siblings/own?
- How did you know what to do? Your SLT told you, told your parent, wrote down?
- How did you find it?
 - Understanding: Did you understand what to do?
 - Difficulty: Was it easy or hard?
 - Quantity: Was it too much or too little?
- How did you feel when doing home practice? (emotion prompts)
- Tell me about what was useful/fun
- Tell me about what not was useful/fun
- Were there any times you weren't sure what to do? Tell me about that
 - Did you ask for help?
 - How did you feel
- If you were the SLT would you change anything about you would give home practice?
- Do you doing homework helped you with your speech/language? Why/why not?
- Do you have any advice for other children/teenagers about doing speech and language therapy home practice?

Appendix 12: Fictional Narrative Read During Interviews

**Sarah is 9 years old.
She likes listening to music and
playing basketball.**

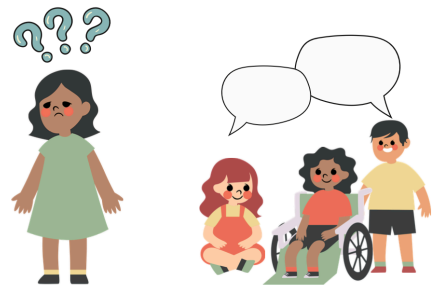


1

**Sarah likes playing with her
friends in school.**



**But sometimes she finds it hard
to understand her friends, and
think of the right words to say.**



2

**One day, Sarah's dad brought her
to speech and language therapy.**

**Her speech and language
therapist helped her to learn and
remember new words.**



3

**Sometimes the speech and
language therapist gave Sarah
activities to do at home.**



She filled in
worksheets



She played games
with her dad



She practiced using a
dictionary in school.

4

Sometimes it was fun to do speech and language activities.



Other times she didn't want to do it. She was too tired and bored.



5

After a while, Sarah found it easier to talk to her friends at school.



6

Appendix 13: Dog Man Themed Multiple Choice Questions

Dog Man Secret Mission

 **Case File:** Children don't like their speech and language therapy homework and won't complete it!

 **Objective:** Find clues about what makes homework easy or hard.

 **How?** Answer the questions below and help Dog Man crack the case!



 **Clue 1: When do you usually do your speech and language therapy homework?**

-  Right after school
-  Before bedtime
-  After playing
-  Different times during the day
-  I don't always do it

Clue 2: What kind of home practice do you normally get?

-  Games and activities
-  Talking practice with someone
-  Worksheets and writing tasks
-  Watching videos
-  Games on a computer/iPad
-  Somethings else?



 **Clue 3: What makes speech homework tricky?**

-  I don't always understand it
-  It takes too long
-  I forget
-  I don't feel like doing it
-  Something else?

Clue 4: How could speech homework be more fun?

-  Turning it into a game
-  Doing it with a friend or family member
-  Using a computer or iPad more
-  Having a special reward for finishing
-  Something else?



 **Clue 5: How do you feel after finishing your speech and language homework?**

-  Proud and happy
-  Relieved it's done
-  Tired
-  Frustrated
-  I don't feel much different

Clue 6: What do you think we should name it?

-  Homework
-  Home Practice
-  Activities
-  Goals
-  Something else?





 **Clue 7:** Draw a picture of what you wish speech and language therapy homework would be like

MISSION COMPLETE!

 **CONGRATULATIONS,**
DETECTIVE _____ 

You helped Dog Man solve the mystery of speech and language homework!



 **Detective Signature:** _____

 **Date:** _____



Appendix 14: Visuals Used During Interviews



Worksheets



Games/toys



flashcards



Computer/
Phone / apps



Chatting



Reading books



Practicing things
you learnt at home



Practicing things
you learnt at school



No home practice

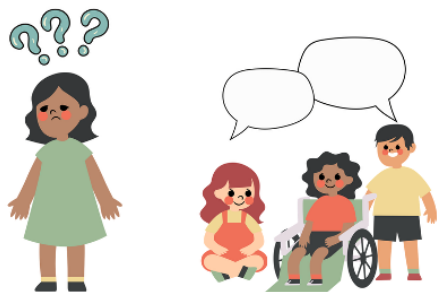


Something else?

A research project on children's views of speech and language therapy homework

What was this study about?

- Some children find talking, understanding, or communicating tricky. Speech and language therapy helps children work on these skills.



- Many children are given “home practice” (or homework) to do between speech and language therapy sessions to help them use their new skills at home, at school, or with friends.



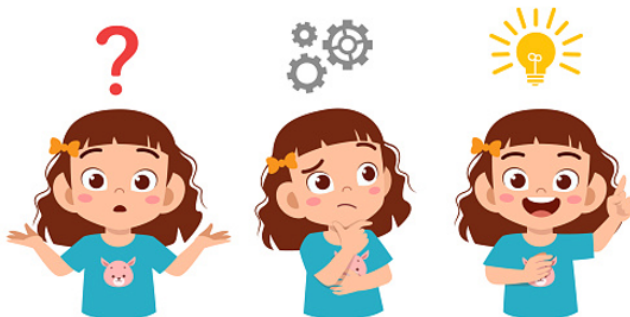
- But not many studies have asked children what they think about home practice. This study wanted to listen to children's views and ideas.

What did the research do?

- First, it looked at other research to see what children have shared about going to speech and language therapy.
- It found that children are not always involved in decisions about their therapy, but they have lots of ideas about what they liked and didn't like about it. Very few children talked about their opinions of home practice.



- Then, 5 children aged 7-12 years were interviewed.
- They talked about what helps, what makes it harder, and how it could be improved.



What are the main results?

- Children like to understand why they are doing therapy and home practice. They feel motivated when they help choose their own goals.



- Home practice can be really helpful, but often it feels like too much, or it is not fun.



- Practicing skills is better when it is fun, includes games, and involves the things you are interested in. It should not be too easy or too hard.



- Getting support from family, friends, teachers, and therapists makes a big difference.



- Being allowed to make choices and having options makes home practice better.

What does this mean?

- Children's ideas are important and should be listened to.
- Home practice can be made better for everyone by including children in the design and ideas.



- Children and their families need more help to feel confident practicing at home.
- We might need to make some changes to how speech and language therapy is done so it better includes children's ideas.



Thank you to everyone who took part in this study to help us learn how to make speech and language therapy better.

