Oscailt

Needs Analysis on Multidisciplinary Support in DEIS schools in Limerick City

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List of Abbreviations

ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AON	Assessment of Need
ASD	Autism Spectrum Difference
CAMHS	Child and Adolescent Mental Health Services
CCNX	The City Connects Programme
CDNT	Children's Disability Network Teams
CDU	Curriculum Development Unit
CHO	Community Health Organisation
CPD	Continuing Professional Development
CPS	Counselling in Primary Schools
CSO	Central Statistics Office
DCD	Developmental Coordination Disorder
DE	Department of Education
DEIS	Delivering Equality of Opportunity in Schools
DES	Department of Education and Skills
EAL	English as an Additional Language
ECCE	Early Childhood Care and Education
ED	Electoral Division
EDNIP	Embracing Diversity and Nurture Integration Project
ELC	Early Learning and Care
EPSEN	Education for Persons with Special Educational Needs
ESIF	Economic and Social Intervention Fund
ESRI	Economic and Social Research Institute
ETSS	Educational Therapy Support Service
EWO	Education Welfare Officer
EWS	Educational Welfare Services
GAA	Gaelic Athletic Association
GDPR	General Data Protection Regulation
GP	General Practitioner
HAPPEE	Health Alliances for Practice-Based Professional Education and Engagement
HP	Haase and Pratschke
HSCL	Home School Community Liaison
HSE	Health Service Executive
ICT	Information and Communication Technologies

IPAS	International Protection Accommodation Services
LRFIP	Limerick Regeneration Framework Implementation Plan
MDT	Multidisciplinary Teams
MIC	Mary Immaculate College
MIREC	Mary Immaculate College Research Ethics Committee
NCCA	National Council for Curriculum and Assessment
NCCCI	The National Centre City Connects Ireland
NCSE	National Council for Special Education
NEIC	Northeast Inner-City
NEPS	National Educational Psychological Services
OECD	Organisation for Economic Co-operation and Development
OT	Occupational Therapy
PDS	Progressing Disability Services
POD	Primary Online Database
P-POD	Post Primary Online Database
PTMF	Power Threat Meaning Framework
PQ	Parliamentary Question
P4C	Partnering for Change
SCPA	Scheme for the Commissioning of Psychological Assessments
SCP	School Completion Programme
SENO	Special Educational Needs Organiser
SNA	Special Needs Assistant
SENCO	Special Educational Needs Coordinator
SIH	School-based Integrated Health Care
SIM	School Inclusion Model
SLT	Speech and Language Therapy
SP	Speaker
STEM	Science, Technology, Engineering, and Mathematics
TD	Teachta Dála/Member of the Dáil
TED	Transforming Education Through Dialogue
TESS	Tusla Education Support Service
UL	University of Limerick
UNCRPD	United Nations Convention Rights of Persons with Disabilities
UNCRC	United Nations Convention Rights of the Child

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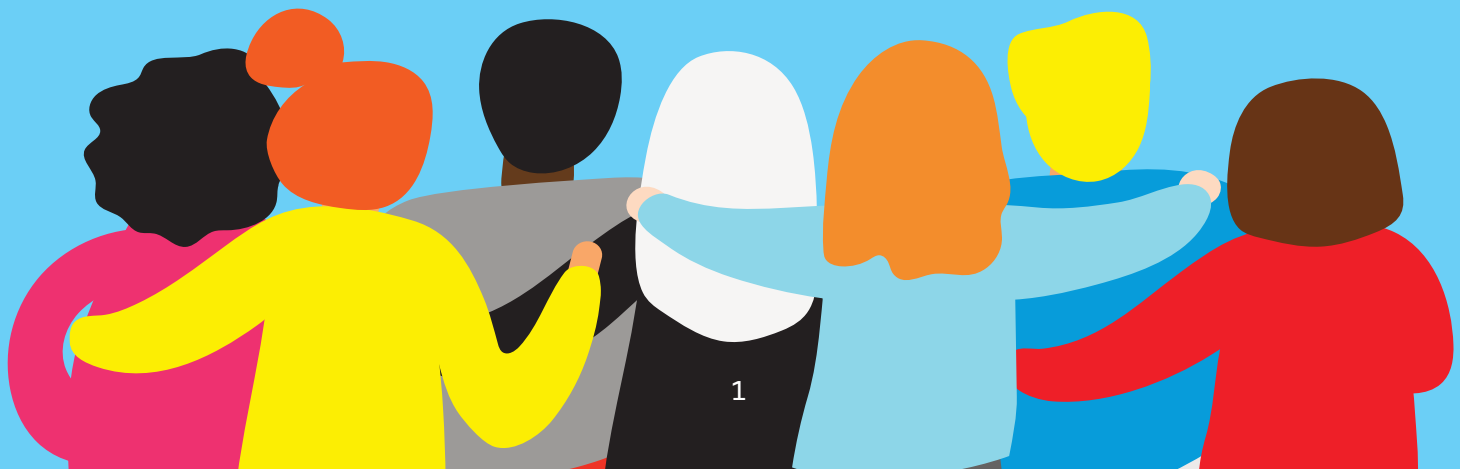
Executive Summary



Introduction to the research

This research was funded by the Limerick Regeneration Economic and Social Intervention Fund and conducted by the Transforming Education through Dialogue Project, Mary Immaculate College (MIC), on behalf of the Oscailt Network of DEIS Band 1 primary and post-primary schools in Limerick City.

Oscailt principals' growing concerns in 2022 about the negative impact of COVID school closures and mass disruption to a variety of support services on the academic development and mental health needs of children prompted this report. Principals highlighted the need for delivery of onsite therapeutic and other multidisciplinary supports such as speech and language support, emotional and behavioural support and support for students who had experienced trauma. **School-based multidisciplinary support** refers to the collaborative effort of professionals from various fields, such as teachers, psychologists and healthcare providers, to address the diverse needs of students. Such multidisciplinary collaboration can enhance student outcomes by creating inclusive learning environments and a holistic response to students' needs in contexts of trauma, poverty and complexity. The research collected a wealth of rich data through surveys, focus groups and individual interviews which has been synopsised and presented here to convey the scale and complexity of the multidisciplinary and other support needs amongst students, the complexity of the teaching and learning environment and the challenges faced by students, parents, school staff and multidisciplinary professionals as a result of lack of multidisciplinary service provision in Oscailt schools and Regeneration communities.

Section One details the background to the research, the Oscailt network, Limerick Regeneration and Limerick's Mayoral Plan which recognises disparity in key indicators of health and education and commits to giving political visibility to issues of social exclusion. Data on wait lists for relevant multidisciplinary services in Limerick is presented and an overview of the report is provided.

Socio-economic context to Limerick City and DEIS school context

Section Two of the report outlines the socio-economic context of Limerick City and Limerick Regeneration communities with reference to enrolment of students in Oscailt schools. Census 2022 revealed that Limerick City has the 4 most disadvantaged Electoral Divisions (EDs) in the country and a total of 7 of the 10 most disadvantaged EDs in the state (Pobal, 2024). Limerick also has the most unemployment blackspots in the country (Watters, 2024). Oscailt schools all serve children and families living in EDs and Small Areas that are categorised under the Pobal HP Deprivation Index as Extremely Disadvantaged, Very Disadvantaged and Disadvantaged. The demographics of student enrolment across the Oscailt schools varies; some have greater numbers of students from the Traveller community and others have higher numbers of students from migrant backgrounds. It is well established that DEIS schools have greater prevalence of students from the Traveller community, from non-English speaking backgrounds and students with special education needs (Smyth et. al, 2015). While there are many valuable supports in the

DEIS scheme, as detailed in Section Two, differences persist in outcomes for students from socio-economically disadvantaged backgrounds, and Traveller and Roma students and despite improvements over the last decade, gaps still exist in achievement between DEIS and non DEIS schools (OECD, 2024). There are implications subsequently for teaching and learning in DEIS schools and for school staff in terms of responding to student support needs arising from complex social contexts. DEIS schools also face challenges meeting the needs of students considering lengthy wait times for assessments and services, particularly in the health sector, in addition to weak service integration (OECD, 2024).

Multidisciplinary collaboration, policy context and models of support

Section Three outlines the importance of multidisciplinary collaboration, its definitions, components, benefits, and barriers. It then delineates the context of health and education policy and provision in Ireland, focusing on the shift towards integrated, school-based therapy services. Traditionally in Ireland therapy services for children have followed a clinic-based model. Health Service Executive (HSE) and non-statutory organisation services such as Occupational Therapy, Physiotherapy, Psychology and Speech and Language Therapy developed independently over time resulting in a wide variation in the services available in different parts of the country and for different needs. The Progressing Disability Services for Children and Young People framework (PDS) was established by the HSE in 2010 to unify and integrate service provision with collaboration between the health and education sectors and to improve equity of access to services. Services can be accessed through Primary Care in the local community or through Children's Disability Network Teams (CDNT) if children's needs are more complex. While not required to access services, parents/guardians or a personal advocate can apply for an Assessment of Need (AON) for a child, a separate legal process set out under the Disability Act (2005) to identify children's health needs and services required to meet their needs. Due to lengthy wait lists for services currently, the demand for AONs has increased significantly, resulting in over 14,220 children waiting for an AON in Ireland at the time of publication. The National Educational Psychology Service (NEPS) provides a range of services to identify educational needs through casework with individual children, staff development, ongoing advice and support for schools and psychological support for critical incidents. In 2024, the OECD emphasised that the allocation of time from NEPS psychologists was insufficient for DEIS schools and acknowledged recruitment challenges in the education and healthcare sectors as well as the need for greater cross-departmental planning. Recent Government initiatives and pilots in education that provide multidisciplinary support are examined. International, national and local models of in-school therapy and systems of integrated student support are also outlined.

Research methodology

The aim of the research and methodology are delineated in Section Four. The research aimed to establish the level of need for onsite multidisciplinary support in Oscailt schools to improve the overall quality of

life, mental health and wellbeing of the students who attend the schools. A mixed methods research methodology was adopted. Data was collected from students, parents, school staff and multidisciplinary professionals through focus groups and interviews and through principal, school staff and multidisciplinary professional surveys. Through a Photovoice study, three children with multidisciplinary support needs used photos they took to facilitate sharing their day-to-day experience of school and provide a platform for them to advocate for improvements in their experience, should they wish to do so.

Research findings

The research findings are detailed in Section Five. Part one focuses on understanding the schools that participated in the research. Based on data from the 11 principal surveys, 2,714 students were enrolled in their schools at the time of data collection and schools ranged in size from 34 to 624 students. A wide variety of children's strengths were shared by school staff in focus groups and interviews. Both diagnosed and undiagnosed support needs were also identified in detail across multidisciplinary and other areas, many of which were exacerbated following COVID.

Greatest areas of need for support

Survey data from school staff and principals ranked the following as the most prevalent areas of need in the following order: emotional and behavioural needs, family context - separation/divorce/single-parent family, community context (needs arising from inequalities in the community such as community violence, lack of services etc.), speech and language and social skills. Oscailt schools play a significant role in meeting the non-academic needs of students and their parents in addition to nurturing their overall well-being and development. The Photovoice study emphasised the importance of creating creative, relaxing, and supportive environments for students with multidisciplinary needs confirming the significance of focusing on the non-academic aspects of school life. The substantial efforts Oscailt schools make to support parents, particularly through the HSCL role, were relayed by school staff.

Current onsite multidisciplinary support

Part two of the findings delineates current onsite multidisciplinary supports available in Oscailt schools and the referral processes that schools use to provide or access support for students. Principals and school staff indicated that students had access to multidisciplinary consultative/therapeutic support onsite in their school. The most prevalent supports cited in surveys were Creative Therapies (Art, Music and Play Therapy), Educational Psychology and Speech and Language Therapy. Levels of onsite delivery of multidisciplinary support varied across the schools depending on the resources available. Most multidisciplinary professionals had experience of working onsite in an educational setting.

Referral process

The referral process for multidisciplinary support and assessment is quite complex, and many commented that for parents in particular, the process can be quite difficult to understand and navigate. A

range of challenges are detailed including lengthy wait lists, complicated referral processes, the costs associated with private services and inadequacy of short-term initiatives to meet long-term needs of children. Multiple barriers to parents bringing children to clinic-based appointments were identified including transport and childcare, parents working during the school day, parental literacy or English language skills, children not being comfortable in the clinic setting, lack of trust in statutory providers and personal circumstances of parents who may be in crisis.

Benefits and challenges of multidisciplinary support onsite in schools

Part three of the findings explores benefits and challenges of onsite delivery of multidisciplinary support according to research participants. While all principals and most parents and school staff stated a preference for onsite delivery in schools, children's feedback was mixed. The main concerns they expressed were lack of privacy and feeling embarrassed, for example, if others in the class were aware of a therapist being present to observe them. Most multidisciplinary professionals were in favour of delivering services both onsite in school and in clinic-based settings. Survey responses indicate that they experience the greatest level of attendance at appointments onsite in schools. Many benefits of onsite delivery in schools for children, parents, school staff and multidisciplinary professionals were cited. These included: less financial pressure on parents, children being more comfortable in the school environment, services being more accessible, missing less time out of class, early intervention and prevention and a more holistic approach to children's needs. Parental trust in and positive relationships with schools were felt to facilitate greater parental engagement, which in turn helps to build trust between parents and multidisciplinary professionals. Benefits for school staff included opportunities for consultation, guidance, collaboration, learning and receiving support from multidisciplinary professionals about how best to meet children's needs. For multidisciplinary professionals and service providers benefits cited included reduction in wait lists, fewer cancellations and no-shows, more cost-effective service delivery, greater understanding of children's needs by seeing them in the day-to-day school environment and enhanced communication and collaboration with school staff to meet students' needs. Challenges identified related mainly to lack of suitable space in schools for delivery of services, scheduling appointments in busy school schedules, and maintaining children's privacy. Key considerations highlighted by research participants for onsite delivery of multidisciplinary supports included greater provision of services, sustainable funding sources, the need for multidisciplinary professionals to understand the school environment, the need to develop relationships between multidisciplinary professionals and parents and the need for an integrated, holistic model of support.

Key learning, implications and recommendations

Key learning

Finally, Section Five sets out the key learning from the research and implications and recommendations for practice, policy and research. The current systems of multidisciplinary support are inefficient and not meeting the needs of students from Oscailt schools and Regeneration communities and, therefore, not fit

for purpose. As a result, the onus of meeting students' needs falls to Oscailt schools who provide a significant level of support for students and their families. A greater level of resourcing is urgently required to meet the variety and complexity of multidisciplinary and other support needs of students. Priority areas identified include emotional and behavioural support, support for separation/divorce/single-parent family, community context, speech and language and social skills. The main services identified by research participants to respond to students' needs are: Creative Therapies, Family Services, CAMHS and NEPS. Other gaps identified include support for children in crisis, after school support and facilities for extracurricular activities. Varied levels of multidisciplinary supports exist across Oscailt schools. However, the short-term nature of many initiatives is not sufficient to meet students' needs. A greater number of psychological assessments are required from NEPS.

The referral process and pathways are complex and confusing. Lengthy wait lists are compounded by systemic issues such as chronic lack of resources, lack of cover for staff on statutory leave, recruitment challenges and the lingering impact of COVID. Short-term 'stop-gap' interventions by statutory services were deemed insufficient and 'tick the box' exercises considering the scale of needs presenting in schools. Onsite delivery of multidisciplinary support alleviates many barriers to children's attendance at appointments, particularly parental lack of trust in services. There are many potential benefits, the most immediate being maximising resources, greater uptake of services due to high levels of student attendance at school and reduction of wait lists. Key challenges include maintaining student's privacy and lack of appropriate space in schools for therapeutic support. Moving forward, key considerations include the urgent need for greater service provision to meet children's needs, sustainable long-term funding and joined up thinking and flexibility between service providers and schools. A structured, consistent, holistic and integrated model of multidisciplinary support is required involving collaboration between Oscailt schools and multidisciplinary services.

Implications

This report identifies the need for a child and young person-centred approach that operates from a human rights perspective and places their needs at the locus of systems of support as opposed to service provider needs. The lack of integration, cohesion and flexibility between various parts of the multidisciplinary support systems highlights the requirement for a cohesive and integrated response from a variety of sources in Limerick City, including schools and a variety of statutory, community and voluntary agencies. The referral systems and multidisciplinary support pathways must be reviewed with a view to providing a holistic, integrated and cohesive approach for children and young people in Oscailt schools based on their needs. The model of integrated student support in the NEIC, Dublin, in which a Multidisciplinary Team and City Connects were implemented in tandem, would help to bring systemic cohesion to area-based service delivery in Regeneration communities.

Recommendations

A key recommendation is the establishment a Student Support Working Group that will work in collaboration with Oscailt principals, relevant statutory and community and voluntary multidisciplinary

providers and other stakeholders to review multidisciplinary support in Oscailt schools and Regeneration communities. This will entail a review and audit of wait lists for services and development of a framework and plan to meet the multidisciplinary and other support needs of children and young people. The framework and plan should identify priority areas for support, include proposals to streamline access to services, address barriers in the referral process, and specify how the various statutory, community and voluntary agencies and schools will work together to meet the multidisciplinary needs of children and young people in Oscailt schools and Regeneration communities. To ensure a cohesive and integrated response to the multiplex of needs of students identified in this report, an integrated system of student support should be implemented in Oscailt schools, such as, City Connects and the Multidisciplinary Team currently being implemented in the NEIC, Dublin.

Given the socio-economic profile of Limerick City, support is required from across Government through an inter-departmental response to ensure that statutory service providers engage with schools and local stakeholders to meet the needs of these students. The level of provision by NEPS Educational Psychologists for Oscailt schools must be reviewed and enhanced. Additionally, Oscailt schools are well situated for the implementation of a variety of Department of Education initiatives to tackle inequality and improve outcomes for the most disadvantaged students such as the proposed DEIS Plus programme, City Connects and the Education Therapy Support Service.

Section 1

Introduction and context to the research

Section 1 – Introduction and context to the research

Funded by the Limerick Regeneration Economic and Social Intervention Fund (ESIF), this research was conducted by the Transforming Education through Dialogue (TED) Project, Mary Immaculate College (MIC), on behalf of the Oscailt Network of DEIS[1] Band 1 primary and post-primary schools in Limerick City.

TED Project

The TED project, situated in the Curriculum Development Unit (CDU), was established within MIC in 1998 and works to promote equity of outcome for all children. TED is a strategic partnership between MIC and DEIS schools, supporting children living with the challenges of poverty and marginalisation, and agencies and organisations of the Limerick region and beyond. TED works in partnership with a variety of key stakeholders, delivers intervention projects, facilitates three networks of DEIS schools, leads and collaborates on high profile research projects and works to inform policy and to impact practice through working with undergraduate and post graduate students in Initial Teacher Education programmes.

Oscailt Network

The Oscailt network of DEIS primary and post-primary schools was formed in 2009, in partnership with the Department of Education and Skills and the TED Project, MIC to support the schools during the Dormant Accounts funded scheme to 'Enable DEIS Schools in Limerick City to Open After School Hours to Maximise Community Use of Premises and Facilities' (Full report available HERE). The principals decided to continue to work together post Dormant Accounts funding as the network provided a valuable forum of support for DEIS schools (Bourke, 2023).

The Mission Statement of Oscailt, *'Opening Schools for Life, Learning and Leisure',* encapsulates the commitment of schools to the holistic growth and development of children, families and communities. Oscailt is currently facilitated by the TED Project in MIC.

Information collected from Oscailt principals in April 2022 about the impact of COVID on students' mental health and wellbeing and support services required highlighted the urgent need for supports for children due to the impact of school closures and mass disruption to a variety of support services. This is reflective of the exacerbation of existing inequalities by the pandemic, as reported by the Ombudsman for Children (2022). Children with mental health difficulties, children experiencing homelessness, Traveller and Roma children, children with disabilities and children living in Direct Provision were disproportionately affected by school closures and lockdowns (ibid). In addition to concerns for the academic development and

[1] DEIS stands for Delivering Equality of Opportunity in Schools and is the Irish government Action Plan for Educational Inclusion, which was launched in May 2005 and remains the Department of Education policy instrument to address educational disadvantage. The second Action Plan was introduced in September 2017.

mental health needs of children, Oscailt schools highlighted the need for onsite delivery of therapeutic and other multidisciplinary supports such as speech and language therapy, emotional and behavioural support and support for students who had experienced trauma. Following discussion with various stakeholders about what could be done to progress onsite multidisciplinary support in our schools, Oscailt decided to apply for funding to conduct a needs analysis. The aims of the research were to establish the level of need for multidisciplinary support in Oscailt schools, to provide guidance on how same might be delivered and to use the research findings to leverage funding and support from state agencies for the delivery of same in and for Regeneration communities. Hearing the voices of children, parents, and school staff in Oscailt schools and those of multidisciplinary professionals was essential to achieving the research aims.

Limerick Regeneration

Regeneration in Limerick City aims to foster physical, economic and social growth to revitalize the urban landscape of the city:

> **Social:** e.g. Education and learning initiatives, health and well-being of families, targeted support for families and youth at risk of difficulty, community development.
> **Economic:** Social innovation and social enterprise hubs, economic engagement, developing a 'knowledge' economy focusing on local skills.
> **Physical**: Improve the quality of local areas, new housing construction, refurbishing existing accommodation and building further capacity. (See https://www.limerick.ie/council/services/housing/regeneration)

The overall vision of the Limerick Regeneration Programme is to create 'safe and sustainable communities of opportunity where people of all ages enjoy a good quality of life, a decent home and a sense of pride about their place'. The objectives are set out under the Limerick Regeneration Framework Implementation Plan (LRFIP), which was adopted by Limerick City and County Council in 2014 (Full document available HERE).

A key element of the LRFIP has been the Economic and Social Intervention Fund (ESIF), which made €36 million euro funding available for programmes in the following categories from 2014-2023: Community, Education and Learning, Families and Youth at Risk, Employability and Work, and Health, Wellbeing and Ageing Well. At the end of the LRFIP in 2023, the Department of Housing extended the ESIF to 2024 and subsequently to 2025. This research was funded through ESIF, which had also been an important source of funding for initiatives for students in Oscailt schools over the last number of years. At the time of publication of this report, the future of the ESIF is unclear.

Limerick's Mayoral Plan

In October 2024, Limerick became the first county in Ireland to have a directly elected Mayor. In the Mayoral Programme 2024-2029, Mayor John Moran sets out a vision for Limerick as being more livable with a better quality of life for everyone, more prosperous with equal opportunity for everyone and with all having the right to a more healthy and long life no longer compromised by the quality of local healthcare (2024, p. 6).

Under Section 3 – Social Inclusion and more Equal Opportunities for all, the plan states that:

> Limerick has long suffered and continues to suffer from the effects of social exclusion. Many communities especially in and around our city centre and some key county towns feel excluded within their own county. Key indicators like health, education levels, employment, income show unacceptable outcome variances depending on Eircodes (2024, p. 16).

The Mayor commits to taking a leadership role in giving these issues political visibility. The plan recognizes the critical role of Limerick Regeneration in 'transforming our most vulnerable areas' and while progress has been made, the plan states that 'more work needs to be done 'as problems are still widespread' (ibid). Under the main aspirations for his mayoralty, support for DEIS schools is identified as a key area.

Furthermore, the Mayoral plan expresses deep commitment to developing a More Healthy Limerick and addressing the critical healthcare challenges Limerick faces outlining the intention:

> … to address these inequalities and work towards a healthcare system that serves everyone in our community. The Programme focus will be on accelerating the delivery of primary care centres and advocating for more equitable access to healthcare services for all residents of Limerick (2024, p. 94).

In relation to mental health, the Mayoral plan sets out strong intentions to address mental health issues, identifying the role of the Mayor as 'uniquely positioned to coordinate solutions as this issue intersects with all areas of our local authority's work – housing, public spaces, community services, and planning' (p. 96).

Specific actions related to mental health that are pertinent to this report include:

MH12	Make mental wellbeing of the population of Limerick a key cross-cutting and visible priority for the Mayor and chair a quarterly Task-Force with relevant stakeholders to see credible and significant improvements in mental health wellbeing in Limerick. This Task Force will be charged with identifying if there are ways to streamline the work of agencies and share resources so that the services reach more people, avoid gaps in coverage and eliminate overlaps (p.95).
MH28	Work with relevant government departments to audit all Limerick schools to establish baseline scores for facilities and programmes for Preventative Medicine. We will work with relevant government departments to develop a plan to improve scores for any schools with poor facilities or located in areas where better than average facilities would be more desirable (p.99).

The commitments made in the Mayoral Plan to address inequalities and healthcare challenges for the most vulnerable are welcome given the wait lists that children and young people experience in Limerick for health services, as detailed in the next section.

Wait lists for services in Limerick

Data on wait lists for various HSE multidisciplinary services was accessed from information provided by the HSE in response to Parliamentary Questions (PQs) asked by TDs in the Dáil[2]. It was not possible to access wait lists specific to Limerick City or Regeneration communities from the HSE, which is a limitation of this research. Limerick falls under CHO3[3], which includes Clare and North Tipperary. Figures for some North Tipperary services also include East Limerick. Wait lists for different services are also presented in different ways. The tables presented below are in keeping with how figures were presented by the HSE in the relevant PQs.

Assessment of Need

Table 1 shows the figures for AONs at the end of December 2024.

Table 1 Wait list for Assessment of Need

AONs	Total overdue Exceptional	Overdue/Exceptional Circumstances	Overdue/Not Circumstances
National	14,221		
CHO3	442	4	438
Limerick	221	4	217

[2] *Full details of the PQs are available here https://www.hse.ie/eng/about/personalpq/pq/ . Data was drawn from the following PQs: PQ 1913/25, PQ 46392/24, PQ 46431/24.*

[3] *CHO = Community Health Organisation.*

Child and Adolescent Mental Health Services (CAMHS)

CAMHS provide specialist mental health service to those aged up to 18 years, who have reached the threshold for a diagnosis of moderate to severe mental health disorder that require the input of multidisciplinary mental health teams. CAMHS referrals must be made by a GP or Hospital Doctor. At the end of December 2024, the wait lists for children and young people under 18 for CAMHS for CHO3, which includes Clare, Limerick, North Tipperary was as follows:

Table 2 Child and Adolescent Mental Health Services Wait List

	Total	<12	12 -26 weeks	26 -39 weeks	39 -52 weeks	<52 weeks
National	4,203	1,685	787	699	408	624
CHO3	234	123	52	48	11	

**Combined figure for 39-52 weeks and <52 weeks

Children's Disability Services

There are 93 Children's Disability Network Teams (CDNTs) aligned to 96 Community Healthcare Networks (CHNs) across the country providing services and supports for children aged from birth to 18 years of age. Each CDNT covers a specific geographical area and holds a waiting list for children with complex needs residing in that area. At the end of December 2024, the figures for CHO3 were as follows:

Table 3 Children's Disability Services Wait List (CDNT)

Wait time for initial contact	0-3 months	4-6 months	7-12 months	Over 12 months
CHO3	247	157	298	605

Speech and Language Therapy

The Primary Care Speech and Language Therapy team help children 0-18 years who have speech, language, voice, fluency and social communication differences and difficulties. They also support their families. Wait lists for initial assessment, initial therapy and further therapy for Limerick and North Tipperary East Limerick are detailed in **Table 4**.

Psychology, Occupational Therapy and Physiotherapy

Table 5 combines figures for HSE Psychology, Occupational Therapy and Physiotherapy for those aged 0-4 years and 11 months and 5-17 years and 11 months.

HSE Psychologists see children and families for assessments, advice, psychological therapy and group interventions. They offer a number of different types of services such as Parenting groups, Parent Information Talks and Psychology intervention services e.g. Counselling/ Psychological therapy. Occupational Therapy (OT) helps people to have as much independence and quality of life as possible. Occupational Therapists work with people in the community to overcome limitations caused by injury,

illness, disability or the effects of ageing. Community Physiotherapy services in the HSE help people who have suffered an injury or illness to regain their health or mobility through exercise and movement.

Table 4 Speech and Language Therapy Wait List

Speech and Language Therapy 0-17 years 11 months	0-4 months	4 months 1 day - 8 months	8 months 1 day - 12 months	12 months 1 day - 18 months	18 months 1 day - 24 months	>24 months	Total
Awaiting Initial Assessment - November 2024							
Limerick	122	195	195	254	68	0	834
North Tipperary/East Limerick	178	228	172	90	10	0	678
CHO3	445	607	510	348	78	0	1988
Awaiting Initial Therapy - November 2024							
Limerick	19	26	12	14	1	0	72
North Tipperary/East Limerick	36	18	8	1	0	0	63
CHO3	92	106	43	70	10	2	323
Awaiting Further Therapy - November 2024							
Limerick	138	156	129	92	16	1	532
North Tipperary/East Limerick	107	67	28	30	12	2	246
CHO3	364	333	235	166	44	8	1150

Table 5 HSE Psychology, Occupational Therapy and Physiotherapy Wait Lists

Psychology	0 - ≤ 12 wks	>12 wks - ≤ 26 wks	>26 wks - ≤ 39 wks	>39 wks - ≤ 52 wks	> 52 wks	0 - ≤ 12 wks	>12 wks - ≤ 26 wks	>26 wks - ≤ 39 wks	>39 wks - ≤ 52	> 52 wks	Total
	0-4 years 11 months					5-17 years 11 months					
Limerick	10	18	9	5	22	71	65	59	68	94	421
North Tipperary/ East Limerick	2	8	2	6	4	10	25	45	48	44	194
CHO3 Total	28	31	21	15	28	133	176	185	130	216	963
Occupational Therapy	**0 - ≤ 12 wks**	**>12 wks - ≤ 26 wks**	**>26 wks - ≤ 39 wks**	**>39 wks - ≤ 52 wks**	**> 52 wks**	**0 - ≤ 12 wks**	**>12 wks - ≤ 26 wks**	**>26 wks - ≤ 39 wks**	**>39 wks - ≤ 52**	**> 52 wks**	**Total**
	0-4 years 11 months					5-17 years 11 months					
Limerick	15	16	6	6	10	56	62	72	74	217	534
North Tipperary/ East Limerick	7	11	4	1	2	33	42	46	63	98	307
CHO3 Total	25	34	14	10	12	122	148	156	172	317	1,010
Physiotherapy	**0 - ≤ 12 wks**	**>12 wks - ≤ 26 wks**	**>26 wks - ≤ 39 wks**	**>39 wks - ≤ 52 wks**	**> 52 wks**	**0 - ≤ 12 wks**	**>12 wks - ≤ 26 wks**	**>26 wks - ≤ 39 wks**	**>39 wks - ≤ 52**	**> 52 wks**	**Total**
	0-4 years 11 months					5-17 years 11 months					
Limerick	109	43	10	8	0	78	50	39	21	4	362
North Tipperary/ East Limerick	36	8	5	4	0	55	33	25	25	2	193
CHO3 Total	178	64	16	12	0	173	93	65	46	6	653

Overview of the report

Section Two provides an overview of the socio-economic context of Limerick City and Regeneration communities where students in the Oscailt schools live. The DEIS school context is then examined drawing on various reports and the support provided through the School Support Programme is detailed. Following this, Section Three examines literature on in-school multidisciplinary support to better understand multidisciplinary support and the benefits and challenges of same. This section then outlines the Irish policy context underpinning multidisciplinary support through both the health and education sectors and considers international, national and local models of in-school support and integrated service delivery.

Section Four details the research aims and methodology, the data collection techniques and process, data analysis and limitations of the research and provides an overview of survey respondents.
The research findings are presented in three parts in Section Five. Part One provides insight to the Oscailt schools that participated in the research including the strengths, interests and needs of students. Part Two details current multidisciplinary support delivered in these schools, examines the referrals process and outlines the benefits and challenges of in-school multidisciplinary support from research participants' perspectives.

Finally, Section Six considers the findings in relation to the research aims and reflects on the key learning from the research with implications and recommendations for policy, practice and research detailed.

Section 2

Socio-economic context to Limerick and the DEIS school context

Socio-economic and community context to the Oscailt schools in Limerick City

This section contextualises the research by examining the socio-economic profile of Limerick City with reference to relevant findings from the Census data (2022, published 2023) and the Pobal HP Deprivation Index[4] (Haase and Pratschke, 2017).

Numerous reports about Limerick City have provided evidence of the significant impact of poverty and marginalisation on local communities and identified the challenges faced by the families, children and staff that live and work there (see FitzGerald, 2007; Hourigan, 2011; Humphreys et al., 2011 for detailed reports). Daily, Oscailt schools directly support children and families experiencing poverty, homelessness, trauma, suicide, family addiction, imprisonment, crime and drug dealing in the local community, families who have fled to Ireland from extremely traumatic situations and war-torn countries, and domestic violence and abuse.

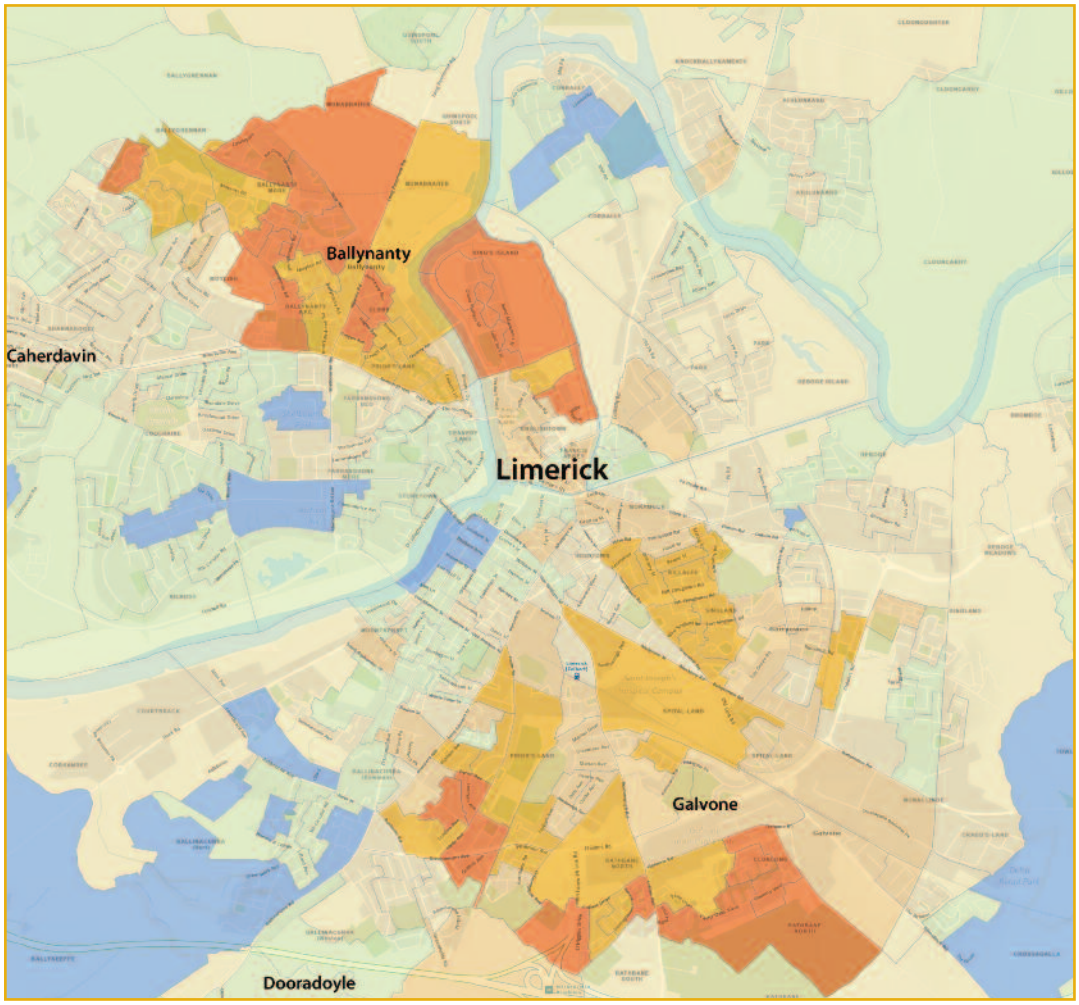
Figure 1 below is taken from Pobal Maps[5] and shows the socio-economic status of the core Small Areas and Electoral Divisions (EDs) of Limerick City. The index ranges from extremely disadvantaged, in red to extremely affluent in dark blue[6]. Recent census data (CSO, 2022) reveals that Limerick City has the 4 most disadvantaged EDs in the country and a total of 7 of the 10 most disadvantaged EDs in the state (Pobal, 2024). Oscailt schools all serve children and families living in EDs and Small Areas that are categorised under the Pobal HP Deprivation Index as Extremely Disadvantaged, Very Disadvantaged and Disadvantaged (See Appendix 1 – **Table 14**, which outlines the HP Deprivation Index score and classification for each ED).

[4] Pobal HP Deprivation Index - Haase and Pratschke developed the census-based deprivation index for the Republic of Ireland. It is applied by several government departments, state and semi-state agencies, voluntary and non-governmental organisations to inform evidence-based policies, leading to greater efficiency in service delivery http://trutzhaase.eu/services/hp_deprivation_index/. It uses data from Census 2022, analysing ten measures of an area's levels of disadvantage. These include educational attainment, employment status and the numbers living in individual households.

[5] Pobal 2025 Limerick City [map] available: https://data.pobal.ie/portal/apps/experiencebuilder/experience/?id=3b0acba7eb694ffa85340a60f81d516c [accessed 11 Mar 2025].

[6] Red=Extremely disadvantaged, Dark orange=Very disadvantaged, Orange=Disadvantaged, Pale orange=Marginally below average, Green=Marginally above average, Pale blue=Affluent, Blue=Very affluent, Dark blue=Extremely affluent.

Figure 1 Pobal Map of Limerick City



(Pobal, 2025)

In addition, the 2022 Census reveals that there are 12 Extremely Disadvantaged Small Areas within these EDs, with scores ranging from -30.3 to -52.70 (See Appendix 1 - **Table 15**). HP Index Scores measure levels of affluence or deprivation relative to the national mean at a given point in time. In comparison to Cork, Dublin and Galway cities, and Waterford Municipal District, **Table 6** shows the percentage of people living in Small Areas categorised as Very or Extremely Disadvantaged in Limerick Municipal District (12.1%) is far greater.

Table 6 Percentage of people living in Very or Extremely Disadvantaged Small Areas

Cork City	6.8%
Dublin City	7.0%
Galway City	1.0%
Limerick Municipal District	12.1%
Waterford Municipal District	5.8%

When viewed by former Local Authority Area parameters, **Table 7** reveals a stark difference in comparison between the percentage of residents living in Very or Extremely Disadvantaged Small Areas: Limerick City (21.8%) is more than 3 times that of Dublin City (7%) and far greater than Cork (6.8%) or Waterford City (8%).

Table 7 Old Local Authority Area % in Very or Extremely Disadvantaged Small Areas

Cork City	6.8%
Dublin City	7.0%
Galway City	1.0%
Limerick City	21.8%
Waterford City	8.0%

In terms of unemployment trends, Census 2022 revealed that Limerick City accounts for 42% of the ED-based unemployment blackspots identified nationally. In total, Limerick has the largest number of unemployment blackspots in the country with 8 out of 50 EDs (16%) in the City of Limerick comprising unemployment blackspots. This is followed by Waterford City and County at 3 blackspots and Cavan with only 2 (Watters, 2024). At ED level, St. Laurence (46.5%) and John's A (33.6%) in Limerick City had the highest unemployment rates nationally in April 2022 (as measured by Principal Economic Status) (ibid). **Table 8** reveals that the unemployment rate in Limerick Municipal District (10.2%) is higher than the national average (8.2%) and that the average rate for Regeneration areas in Limerick City is 27.4%, more than 3 times the national average.

Table 8 Employment and unemployment rates

Area	Employment Rate	Unemployment Rate
Moyross	34.2%	27.8%
St. Mary's Park	27.6%	33.6%
Southill	34.6%	25.9%
Ballinacurra-Weston	37.4%	25.1%
Limerick Municipal District	52.4%	10.2%
County	53.3%	8.6%
Regeneration	33.8%	27.4%
State	56.1%	8.3%

Table 9 shows massive discrepancies in the average percentage of the population with a third level qualification. In Regeneration areas in Limerick City the rate is 10.9%, with a range of 5.6% - 16.7%. For Limerick Municipal District the rate is 41.2%, which is slightly below the national average of 44.9%. Moreover, these areas have much higher percentages of the adult population with primary level education or less and upper secondary education.

Table 9 Education levels for adult population

Area	Primary or Less	Upper Secondary	Third Level
Ballinacurra-Weston	24.0%	27.2%	16.7%
Moyross	29.4%	31.7%	10.6%
St. Mary's Park	32.9%	29.6%	5.6%
Southill	26.3%	25.6%	11.3%
Regeneration	28.1%	28.6%	10.9%
Limerick Municipal District	9.3%	24.2%	42.1%
County	10.3%	25.6%	41.2%
State	9.8%	25.6%	44.9%

Table 10 below shows the significant difference between the national average of the population who hold citizenship other than Irish (12.9%) and EDs in Limerick City centre area, which range from 39.8% to 68.5%.

Table 10 Citizenship other than Irish

ED	% non-Irish citizenship
Shannon A	68.5%
Custom House	58%
Shannon B	57.4%
Dock A	52.6%
Market	49.5%
Dock B	39.8%
Limerick Metropolitan District	15.6%
County	11.2%
Ireland	12.9%

Enrolment in Oscailt schools

Research on the DEIS programme shows that DEIS schools are more likely than non DEIS schools to have children from non-English speaking backgrounds, Traveller backgrounds and with Special Education Needs (Smyth et al., 2015). We can see this reflected in enrolment in Oscailt schools. In 2024-2025, the average number of Special Education Teaching (SET) hours allocated to Oscailt schools was 216.2, with a range of 97.5 to 450 hours. The average number of SET posts allocated was 8.8, with a range of 3.9 to 15.8. Furthermore, across Oscailt schools there is a diverse student body, and some schools have high enrolment of children from migrant backgrounds or from Traveller backgrounds. Across five of the schools involved in EDNIP[7], for example, there are children and families from 72 nationalities, speaking 67

[7] The Embracing Diversity and Nurture Integration Project (EDNIP) is a partnership project developed with the main aim of supporting schools to embrace diversity and foster integration. The need for EDNIP was identified by schools and led by the Transforming Education through Dialogue (TED) school networks at Mary Immaculate College, Limerick. The report highlights the story of the evolution, model and outcomes of the five participating schools - St. Michael's Infant School, Scoil Iosagáin CBS Primary School, Presentation Primary School, Our Lady of Lourdes Primary School, St John's Girls' and Infant Boys' Primary School, along with Mary Immaculate College, Department of Education, Limerick Education Centre, Limerick and Clare Education and Training Board, Tusla Education Support Service and Limerick City and County Council.

heritage languages and practicing 16 religions. Migrants in Ireland are not a homogenous group. Some migrants are well qualified and proficient in English while in contrast others arrived in Ireland from conflict regions with little resources (Hennessy, 2021). Migrant families, however, are at greater risk of being negatively affected by economic, health, educational, and social inequality, deepened by social isolation.

Some schools in Oscailt have a significant intake of children from Traveller backgrounds. It is nationally recognised that Traveller students are particularly at risk educationally with lower transfer from pre-school to Junior Infants, lower transfer rates to post-primary than the national average, lower rates of completion of Junior Certificate and Leaving Certificate (Government of Ireland, 2023) and only a small percentage progressing to Higher Education (ibid). Peer research by members of Limerick Traveller Network (2025) highlights the structural and cultural barriers faced by Traveller children in education. Only half of the parents of younger primary school children who participated in the research indicated that their child was on a par with their peers, dropping to 44% for age 8-10 and 35% by age 11-12. The research also found that at the end of primary school, a large number of Traveller students were not prepared for post-primary level and that student happiness declined as they progressed through their education.

A number of Oscailt schools enrol children from local International Protection Accommodation Services (IPAS)[8] centres in Limerick and have children living in homeless or emergency accommodation. As of the 30th of March 2025, there were 33,007 adults and children in the 321 IPAS centres in Ireland 9,348 of whom are children. In Limerick City and County, there were 623 people in IPAS accommodation. In January 2025, the number of people who are homeless and living in emergency accommodation stood at a record high nationally at 15,286, including 4,563 children[9]. In the Midwest, the number of homeless children in January 2025 almost doubled from the previous year, standing at 204 children in emergency accommodation. Additionally, 128 families were in homeless accommodation, the majority of whom were single parent families, an increase from 81 in 2024.

DEIS school context

The DEIS programme was first established in 2005, with the first schools entering the programme in 2006, and since then has been supporting schools to help ensure equitable access to education for students from socio-economically disadvantaged backgrounds. It was introduced due to a recognition of the lack of a standardised system for identifying levels of disadvantage within schools (DES 2005). The process of identification has evolved over the last 20 years and has seen an introduction of a more refined and data-driven model through the DEIS Plan 2017 and further updates in 2022. This model incorporates anonymised data from the National Census Small Area Population Statistics (SAPS), the Pobal HP

[8] *The International Protection Accommodation Service (IPAS) provides accommodation and services for people applying for International Protection.*

[9] https://www.rte.ie/news/2025/0228/1499514-homeless-figures-ireland/

Deprivation Index and data from the Department of Education and Youth Primary Online Database (POD) and Post-Primary Online Database (P-POD). As such, it takes into account other important factors and demographics and has improved the accuracy of identifying disadvantaged schools and expanded the programme's coverage. The programme continues to develop and has a significant role in promoting educational equality and inclusion in Ireland. Currently (2024-2025), there are 306 Urban Band 1 Primary, 149 Urban Band 2 Primary, 506 Rural Primary and 232 Post-Primary schools in the DEIS programme.

Since its introduction it has sought to provide targeted supports to schools that have concentrated populations experiencing social and economic disadvantage (OECD, 2024). As established in 'DEIS An Action Plan for Educational Inclusion' (Department of Education and Science 2005, p. 7) the programme is grounded in the following principles:

- Every child and young person deserves an equal chance to access, participate in and benefit from education
- Each person should have the opportunity to reach her/his full educational potential for personal, social and economic reasons and
- Education is a critical factor in promoting social inclusion and economic development

In 2015, an evaluation of the learning from the DEIS programme (Smyth et al., 2015) was published. The report examined all aspects of DEIS, including the impact of its supports, opportunities for collaboration within and between schools, and the integration of services from other departments and agencies to enhance the effectiveness of its interventions. Smyth et al. (2015) observed marked differences between DEIS and non-DEIS schools in terms of social class backgrounds, parental education, household income and family structure of students. In reviewing evaluation research at primary level, they found that despite a significant improvement in achievement in literacy and numeracy test scores over time, there was not a distinct improvement in closing the achievement gap between DEIS and non DEIS schools. At post-primary, the report observed a 'slight but significant' (ibid, p. viii) narrowing of the gap in average Junior Certificate grades over time. Additionally, DEIS post-primary schools had lower rates of completion at junior and senior cycle, but the gap had not narrowed significantly over time.

This subsequently led to the publication of the 'DEIS Plan 2017' (DE, 2017) which builds on the original plan and acknowledges the achievements of the programme since its inception. The *DEIS Plan 2017* sets out five main goals and identified over 100 actions to be used to support the achievement of these goals:

- The implementation of a more robust and responsive assessment framework for the identification of schools and effective resource allocation.
- To improve learning experiences and outcomes for children and young people in DEIS Schools.
- To improve the capacity of school leaders and teachers to engage, plan and deploy resources to their best advantage.
- To support and foster best practice through inter-agency collaboration.
- To support the work of schools by providing research, information, evaluation and feedback.

Numerous evaluations by the Educational Research Centre in recent years (Kavanagh et al., 2017; Gilleece et al., 2020; Nelis and Gileece, 2023) have found that while students' scores in maths and reading at primary level have improved since 2006, and scores in maths, reading and science have improved at post-primary level, the gap in achievement between DEIS and non-DEIS schools has remained persistent over time. Additionally, non DEIS schools have a higher retention rate to Leaving Certificate than DEIS schools (93.4% v's 85%) and a much higher rate of transition to higher education (68.4% v's 40.8%) (Government of Ireland, 2024).

At primary level, the Children's School Lives study (Devine et al., 2024) conducted from 2018-2023 found that there are more children living in poverty (i.e., of low affluence) in DEIS schools in comparison to non-DEIS schools and that DEIS primary schools had a greater prevalence of minority group children (children with a range of additional learning needs) including children of immigrant and Traveller backgrounds. Significant differences were identified in levels of anxiety in Cohort A[10], who started Second Class in 2018, with children in DEIS schools expressing higher anxiety than children in non-DEIS schools. Additionally, children from poorer families in Cohort A, were also significantly more likely to 'worry about what is going to happen'. Teachers and principals in the most socially deprived case study schools referred to the impact of drug addiction, food poverty and trauma in what they identified as 'forgotten' communities (Devine et al., 2024).

In 2024, the Organisation for Economic and Cooperative Development (OECD) published a 'Review of Resourcing to Address Educational Disadvantage in Ireland'. This report highlighted the role of the DEIS programme as a key component to an education system that consistently outperforms many other OECD countries whilst exhibiting relative socio-economic fairness. However, it also highlighted persistent differences in outcomes for students from socio-economically disadvantaged backgrounds, and Traveller and Roma students and, despite improvements over the last decade, gaps still exist between DEIS and non-DEIS schools (OECD, 2024). The review also specified that wait times for assessments, particularly for service provision in the health sector, create a challenge for schools to meet students' needs and that 'weak integration of services continues to undermine day-to-day experiences for children and families' (ibid, p. 18). The review team also observed that, in many cases, schools are required to support parents with coordination of social and health services due to 'limited coordination of these services with the education sector at the system level' (ibid, p. 25). Citing another OECD report, the review draws attention to the challenges that children and young people with complex mental and physical health needs face in accessing appropriate counselling and support due to fragmentation in service delivery and lack of coordination between various departments and agencies. While the holistic approach to support for student wellbeing inherent in the DEIS scheme is recognised by the review, the long wait times for accessing health and therapy services were deemed to undermine the ability of the education system to achieve its aims to be holistic, with negative impacts in particular regarding the intersectionality of students needs around educational disadvantage and special education needs. Finally, the review highlights that many schools indicated that allocation of time from NEPS psychologists was 'insufficient

[10] Children's School Lives was conducted by researchers in University College Dublin on behalf of the NCCA. It followed two cohorts: Cohort A refers to children tracked from Junior Infants (2019) through to 2nd class (2023), while cohort B refers to children tracked from 2nd class (2019) through to 6th class (2023). For further information see https://cslstudy.ie/

to fully provide for a comprehensive educational psychological service' (ibid, p.25). Challenges in recruitment in both education and healthcare were recognised and the need for greater cross-departmental workforce planning is highlighted as essential. Key recommendations of the review include:

- Strengthen equity in provision of additional resources across schools.
- Strengthen the coordination of educational services with the health and therapy service provision to minimise the burden on schools and families in meeting students' needs.
- Review additional costs of education to families to improve the accessibility of provisions.
- Promote promising models and examples of engagement and collaboration with parents and families.

DEIS School Support Programme

The levels of support provided through the DEIS programme are aligned with the classification of schools which are categorised into Primary Urban Band 1, Primary Urban Band 2, Primary Rural, and Post-Primary categories. The level of resources and supports that are provided depends on each school's classification and is based on 1) the school's individual level of disadvantage and 2) the location of the individual school (DE, 2017).

Primary Urban Band 1 Supports[11]

Reduced class size is one of the main additional supports that DEIS Urban Band 1 schools receive when compared to other classifications. According to 'Circular 0011/2024 Staffing arrangements in Primary Schools for the 2024/25 school year' the current staffing arrangements and specific ratios for DEIS Urban Band 1 schools are as follows:

- 17:1 for junior schools
- 19:1 for vertical schools
- 21:1 for senior schools

Further supports that are available for DEIS Urban Band 1 schools are outlined below (DE, 2024a; OECD, 2024):

- Administrative principal appointed on an enrolment of ***113*** pupils. An administrative deputy principal can be appointed on an enrolment of ***500*** pupils (OECD, 2024).
- DEIS grant paid based on the level of disadvantage and enrolment.
- Access to Home School Community Liaison Services (HSCL) (See below for more details).
- Access to School Meals Programme.
- Access to range of supports under School Completion Programme (SCP) (See below for more details).
- Access to literacy/numeracy support such as Reading Recovery, Maths Recovery, First Steps, Ready Set Go Maths.
- Access to planning supports.
- Access to a range of professional development supports for teachers.

[11] *All primary schools in Oscailt are Urban DEIS Band 1. For details of DEIS Band 2 and DEIS Rural Primary support see https://www.gov.ie/en/department-of-education/policy-information/deis-delivering-equality-of-opportunity-in-schools/*

DEIS Post-Primary Schools

Under the post-primary system there are a number of supports available such as the DEIS grant, access to Home School Community Liaison Services, access to the School Meals Programme, access to supports under School Completion Programme, access to planning supports and access to a range of professional development supports for teachers.

Home School Community Liaison (HSCL) Services

Established in 1990, the HSCL scheme is funded through the Department of Education and managed by the Tusla Education Support Service (TESS) (DE 2024b). The HSCL Coordinator either works in DEIS Urban Band 1, DEIS Urban Band 2, and all Post-Primary DEIS Schools on a full-time basis in one school or can be shared with another school (Weir et al., 2018).

The role of the HSCL Coordinator is to liaise between the home, the school, and the community with the goal of improving educational outcomes for children and young people (OECD, 2024). HSCL Coordinators focus on improving attendance, participation and retention of children in school (DE, 2024b). The HSCL should also work in an integrated manner with the School Completion Programme (SCP) and the Education Welfare Service (EWS) which along with the HSCL Service are the three strands of TESS (DE, 2024b).

The five main aims of the HSCL Scheme are (Weir et al., 2018):

1. To maximise active participation of the children in the schools of the scheme in the learning process, in particular those who might be at risk of failure.
2. To promote active co-operation between home, school and relevant community agencies in promoting the educational interests of the children.
3. To raise awareness among parents of their own capacities to enhance their children's educational progress and to assist them in developing relevant skills.
4. To enhance the children's uptake from education, their retention in the education system, their continuation to post-compulsory education and to the third level and their attitudes towards life-long learning.
5. To disseminate the positive outcomes of the scheme throughout the school system generally.

School Completion Programme (SCP)

The SCP is a targeted programme of support for primary and post-primary children and young people identified as being at risk of leaving education early or who are out of school and have not successfully transitioned to an alternative learning setting or employment (DE, 2024a). There are 121 SCPs nationally in clusters of primary and post-primary schools. SCP covers 783 schools and over 250,000 students. The SCP aims to ensure that young people remain in education until they complete the Leaving Certificate, an equivalent qualification, or achieve a suitable level of educational attainment that allows them to transition into further education, training, or employment (OECD, 2024). Working in collaboration with

the HSCL Scheme and the statutory EWS, the SCP prioritises improving children's school attendance, active participation, and retention.

SCP offers three distinct types of interventions (OECD, 2024):

- Targeted interventions for children and young people with significant educational welfare needs.
- Brief interventions for those requiring immediate short-term support.
- Evidence-based and evidence-informed interventions at a universal level for whole classes or large groups.

In 2025, the Economic and Social Research Institute (ESRI) published a second review of SCP (Smyth et al., 2025), having already completed one in 2015. Of relevance to this report is that the 2025 review observed considerable changes in the broader societal context with marked increases in school non-attendance being attributed to the impact of the pandemic on wellbeing. Both SCP and school staff highlighted the scale of socio-economic disadvantage evident in the project schools, which is often compounded by additional challenges related to 'parental mental health, addiction and disorder in the local area' (Smyth et al., 2025, p.ix). Several staff reported anxiety and other mental health issues as now being evident among young children, which was not the case to the same extent previously (ibid, p. 16). The report also highlights that SCP staff frequently work with young people with mental health or other complex challenges and a lack of adequate referral pathways for mental health and therapeutic provision in the context of lengthy wait lists for specialist services and lack of alternative education provision for those too young to access Youthreach. Around half of the 121 projects reported offering counselling at least once in SCP schools and these supports are highly targeted on the basis of student and school needs (ibid, p. 36).

School Meals Programme

The Hot School Meals Programme was initially launched in 2019 as a small pilot involving 30 schools and has since expanded significantly (OECD, 2024). As of September 2023, all DEIS primary schools have been eligible to receive a hot meal daily, while DEIS post-primary schools are provided with a cold meal, with the option to choose between lunch or breakfast. In April 2024, the scheme was extended to include all primary schools with approximately 900 primary schools applying to join the programme. This brought the total number of schools receiving hot meals to 1,400 (OECD, 2024).

Programme for Government 2025 support for DEIS schools

The 2025 Programme for Government indicates that the Government will:

- Establish a new DEIS Plus Scheme to support schools with the highest level of educational disadvantage to improve educational outcomes, particularly in literacy and numeracy.
- Expand the Home School Liaison Coordinator Scheme with new posts for schools demonstrating high need.
- Implement a range of recommendations from the recent 'Report on the Review of Out-of-School Education Provision to support school completion'.

Summary

This section provided an overview of the socio-economic context to Limerick City and areas from which the Oscailt schools enrol children. Limerick Municipal District has one of the highest per centages of people living in Very or Extremely Disadvantaged areas, in addition to nearly 42% of the unemployment blackspots in the state. Additionally, some Oscailt schools have very diverse student enrolment including Traveller students and students from migrant backgrounds who are at increased risk of experiencing educational and other forms of inequality, such as health inequality.

The DEIS programme and supports provided for Urban Band 1 primary and post-primary schools and commitments made in the Programme for Government 2025, including the DEIS Plus Programme, were detailed. While the DEIS programme includes many welcome resources for Oscailt schools and families these supports are wholly inadequate in the face of the demographics of the communities Oscailt schools serve, and the socio-economic challenges experienced by families. The OECD 'Review of Resources to Address Educational Disadvantage in Ireland' (2024) emphasised that despite improvements, gaps still exist between DEIS and non-DEIS schools with persistent difference in outcomes for students from socio-economically disadvantaged backgrounds and ethnic minority groups.

Section 3

Literature on multidisciplinary support, the Irish policy context and models of multidisciplinary support

Section 3 – Literature on multidisciplinary support, the Irish policy context and models of multidisciplinary support

> The primary outcome for school-based therapy is to maximise the potential for inclusion and social participation in educational settings for all children. The overarching concept of participation is central and reflects a rights-based approach, whereby all children should have equal opportunities for experience (Lynch et al., 2020, p. 53).

Firstly, this review draws on the literature on in-school multidisciplinary support to outline the importance of multidisciplinary collaboration, its definitions, components, benefits, and barriers. In Ireland, the landscape of multidisciplinary support for children and young people is complicated with responsibility for different services falling under the remit of both the health and education sectors. As such, this section outlines the Irish policy context examining relevant health and education policy and provision, focusing on the shift towards integrated, school-based therapy services. It examines the National Educational Psychological Services, the Special Education Teaching Allocation Model, the School Inclusion Model, the Education Therapy Support Service and relevant commitments made in the recent Programme for Government pertinent to multidisciplinary support. Subsequently, the review delineates various models of in-school support internationally, nationally and locally in Oscailt schools.

By summarising the benefits and challenges of multidisciplinary support, relevant policy and illustrating relevant models, this review aims to provide a comprehensive understanding of how multidisciplinary, school-based therapy services can enhance the inclusion and social participation of all children in educational settings. It underscores the importance of collaborative efforts between health and education professionals to address the diverse needs of students, thereby creating supportive, inclusive, and effective learning environments.

Review on literature on multidisciplinary collaboration

Definitions of multidisciplinary collaboration

Schools are increasingly identifying and initiating creative ways to address non-academic barriers to learning, barriers which include trauma, poverty, community violence and emotional or behavioural difficulties (Mendenhall et al., 2013; Bates et al, 2019). Multidisciplinary collaboration is one such creative strategy used to break down these barriers by responding to the complexity and diversity of student and family needs in a comprehensive manner (Mendenhall et al., 2013). Throughout the literature, collaboration between multidisciplinary professionals is referred to as 'interdisciplinary collaboration' (Bronstein, 2003) or 'interprofessional collaboration' (Stone and Charles, 2018; Bates et al., 2019). For the purposes of this literature review, the term 'multidisciplinary collaboration' will be used.

Bronstein defines multidisciplinary collaboration as 'an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own' (Bronstein, 2003, p. 299). Stone and Charles (2018, p.185) identify it as 'collaborations between social workers and professionals from other disciplines' while Hesjedal et al. describe it as 'an active and ongoing partnership between professionals from different occupational fields' (Hesjedal et al., 2016, p. 842). Bates et al (2019, p.111) define it simply as 'teamwork with individuals from other professions'.

School-based multidisciplinary support refers to the collaborative effort within educational settings whereby professionals from various fields, such as teachers, school psychologists and healthcare providers, collaborate to address the diverse needs of students. This approach integrates the expertise of multiple disciplines to create holistic programmes, which aim to enhance students' academic performance, social-emotional development, and overall wellbeing (Bronstein, 2003; Franklin et al., 2009).

Components of multidisciplinary collaboration

Bronstein (2003) identifies the consistently appearing components of multidisciplinary collaboration as interdependence, newly created professional activities, flexibility, collective ownership of goals and reflection on process. *Interdependence* refers to the reliance on interactions among professionals whereby each is dependent on the other to complete their tasks and includes both formal and informal time spent together. *Newly created professional activities* refer to collaborative acts, structures and programmes that can achieve more than could be achieved by independent action. *Flexibility* includes reaching a compromise and the alteration of roles as professionals respond creatively to need. *Collective ownership of goals* refers to shared responsibility in the achievement of goals. Finally, *reflection on process* refers to the process whereby collaborators reflect on their working relationship in order to strengthen relationships and effectiveness.

Stone and Charles (2018) present five models of interprofessional collaboration among school social workers and other professionals. The models include initiator/coordinator, assessor, intervener, whistle blower and collaborator. The *initiator/coordinator* mode of collaboration focuses on initiating a dialogue between professionals in the school to address a student's needs or connecting the student, family and teacher with resources within and outside of the school. The *assessor* mode of collaboration focuses on the gathering of information about the student. The *intervener* mode of collaboration implements a specific initiative with the student, teacher or family. The *whistle blower* mode focuses on alerting school administrative personnel to the needs of the students and at times the needs of the teachers. The *collaborator* mode includes joint assessment of the student's needs and the co-creation of possible interventions.

In their study of the perceived facilitators of multidisciplinary collaboration, Mendenhall et al. (2013) identified the key components of professional development, leadership, onsite consultation and the sharing of successful and unsuccessful practices with other schools. Additionally, Hesjedal et al. (2016)

found that teachers and social workers in Norway benefitted from sharing important values such as equality, commitment and community when cooperating to support children in difficult conditions and assert that in order to ensure academic success, support is needed from multiple systems. Their study emphasised the importance of an individual plan as a tool to ensure that all parties had the same starting point from which to help the child and underline the importance of all professionals viewing the child as a respected and important partner in the multidisciplinary process. Being available to parents was considered an essential component and the study highlighted the importance of giving parents a forum in which to convey their worries and be heard. Interestingly, the study revealed that the professionals in the teams had a close collaboration with external services, for example, a public health nurse or the police thus acknowledging the importance of being informed and of sharing information through the multidisciplinary teams regarding what was going on in the communities.

Relationship-building, although it takes time, is considered as essential to the successful implementation of school-based multidisciplinary collaboration along with the need to clarify the expectations of all parties (Campbell et al., 2012; Missiuna et al.,2012).

Benefits of school-based multidisciplinary collaboration

Benefits for students

School-based multidisciplinary collaboration has emerged as an effective strategy to address the diverse needs of students most effectively. It requires a move from individualised services focused on remediation of deficits to capacity-building models which allow for increased participation (Missiuna et al., 2012). The collaborative efforts of multidisciplinary teams enable schools to provide tailored interventions and holistic support systems that foster academic success, social-emotional development, and overall wellbeing. Franklin et al. (2009) highlight the positive impact of school social work interventions, often involving multidisciplinary teams, on students' academic performance. Similarly, Lynch at al. (2020) emphasised a number of positive outcomes to school-based therapy support including increased academic engagement, increased positive classroom interactions, increases in positive social interactions for children and increased differentiated instruction.

Rossen and Cowan (2014) and Anaby et al. (2019) outline the benefits of multidisciplinary collaboration in schools, emphasising improvements in students' social-emotional development. Additionally, school-based multidisciplinary teams have been shown to increase access to essential services for students (Franklin et al., 2009) while the presence of multidisciplinary teams in schools may facilitate early identification and timely intervention for potential issues, preventing minor problems from escalating (Dowdy et al., 2010). Ultimately, school-based multidisciplinary collaboration ensures that students receive comprehensive care and support tailored to their individual needs, facilitating their academic progress and social inclusion (Johnson, 2022).

Benefits for professionals

School-based multidisciplinary collaboration offers numerous benefits for professionals involved, fostering an environment that enhances their skills, knowledge, and professional satisfaction. Collaboration fosters stronger professional relationships and networks. These relationships can provide emotional and professional support, reducing burnout and promoting a sense of community among staff members (Thielking et al., 2018).

Multidisciplinary collaboration provides ongoing learning opportunities for professionals from different disciplines, whereby new insights may be gained and new approaches to student care and education may be unearthed (Campbell et al., 2012). Indeed, in their study, Campbell et al. (2012) highlighted the fact that therapists benefitted from spending time in classrooms working with teachers as it forced them to re-evaluate the types of recommendations they had been making – it became clear that many of their recommendations had not been realistic or likely to work in an education setting. Similarly, in one study teacher attitudes and approaches to challenging behaviour were reframed having learned about sensory integration theory (Fitzgerald and McCobb, 2017). Ultimately, the collaborative environment created by school-based multidisciplinary collaboration encourages continuous professional growth and the development of new competencies so that the professionals involved may stay up to date with current practices and theories (Vicek et al., 2020).

Barriers to meaningful multidisciplinary collaboration

In their study examining the mental health needs of young people in the care and youth justice systems in Ireland, McElvaney and Tatlow-Golden (2016) consulted with a range of interdisciplinary professionals concerned with children's mental health including the disciplines of psychiatry, psychology, speech and language therapy and education. They found that meaningful interagency collaboration was essential for better service provision with a holistic, systemic programme at its core. However, a range of barriers to good interagency working were also identified including mismatched expectations between agencies, difficulties with interagency communication and limited resources. Similarly, in their study of the perceived barriers to the adoption and implementation of multidisciplinary collaboration, Mendenhall et al. (2013) highlighted lack of understanding and buy-in by stakeholders, time constraints and lack of funding and resources.

Campbell et al. (2012) identified a range of challenges associated with the effective implementation of school-based collaboration including insufficient time for teachers and therapists to meet, inconsistent presence of therapists in the school setting and confusion about roles and responsibilities within the collaborative partnership. Villeneuve further (2009) identified a lack of understanding among partners of how therapy services help students to progress academically while Lynch et al. (2020) underlined the need for adequate accommodation and for Continuing Professional Development for teachers in participating schools.

Finally, Mendoza-Diaz et al. (2021) acknowledge the primary difficulty which arises when a service model operates in a transitional state between two heavily regulated systems e.g., healthcare and education. This leads to complications in navigating the bureaucratic procedures of each system.

Context of health and education provision in Ireland

This report acknowledges at the outset that there are variations in language which can be used to describe educational needs and disability. As described by the National Disability Authority (2022) for some individuals person-first language, for example, 'a person with a disability' is preferred. On the other hand, some individuals have a preference for identity-first language, for example 'autistic'. As per recent publications (DE 2024h; NCSE 2025), this report will use terms interchangeably to adopt an inclusive approach to language. The authors of this report also acknowledge that terminology such as 'special educational needs' is currently under consideration in the review of the EPSEN Act. However, at the time of writing this document it is the term that is used at present in Irish legislation and as such, this term will be used in the context of this report.

Education policy

Ensuring that all children, including those with disabilities and special educational needs (SEN), receive appropriate and effective education is a fundamental obligation outlined in the Education Act (1998) and the Education for Persons with Special Educational Needs (EPSEN) Act (2004). These legislative frameworks mandate that schools identify and meet the diverse educational needs of every student. Additionally, international agreements such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the UN Convention on the Rights of the Child (UNCRC) outline children and young people's rights to education and healthcare and emphasise the importance of providing high-quality services that empower those with disabilities to lead full and meaningful lives within their communities (Government of Ireland, 2023).

The 2017 DEIS Plan underscores the commitment of the Department of Education and Skills to dismantle barriers and break the cycle of intergenerational disadvantage through comprehensive, cross-departmental strategies (Department of Education and Skills, 2017a). Recent recommendations from the Organisation for Economic and Cooperative Development (OECD) 'Review of Resourcing Schools to Address Educational Disadvantage in Ireland' further advocate for enhanced coordination and integration of services across various departments, including Education, Health, and Children, Equality, Disability, Integration, and Youth, to better support at-risk children (OECD, 2024). Two measures which are informed by the recommendations of the review have been announced: 1) Funding for 12 Community Link Workers who will support Traveller and Roma children and young people as well as those most at risk of educational disadvantage (DE, 2024d); 2) Extending the Counselling in Primary Schools Pilot (CPS-P) 2023-2025 to include 61 urban DEIS primary schools in two locations in Dublin (DE, 2024e).

In alignment with these recommendations, the National Council for Special Education (NCSE) promotes a multidisciplinary approach in its policy advice for an inclusive education system (2024). This model aims to gradually develop an inclusive educational system, fostering collaboration and comprehensive support to achieve optimal outcomes for all students in Irish schools:

> A co-professional education model will assist in the progressive development of an inclusive system over time and contribute to the achievement of the best possible outcomes for students as a joined-up thinking, wrap-around approach to meeting the needs of all students in Irish schools
> (NCSE, 2024, p. 121).

Background to therapy services for children

Traditionally in Ireland, therapy services for children have followed a clinic-based model whereby clients are referred and added to a waiting list, with school-based therapy provision taking place primarily in special school settings, mostly in those run by non-statutory organisations (Lynch et al., 2020). School-based provision has, since 1982, been mostly confined to the Specific Speech and Language Disorder (SSLD) classes where children with developmental or specific speech and language disorders receive intensive Speech and Language Therapy. Here Speech and Language Therapists work with the children in the classroom and thus involve close collaboration with the class teacher (Lynch et al., 2020).

Children's therapeutic services (Occupational Therapy, Physiotherapy, Psychology and Speech and Language Therapy), delivered by the Health Service Executive (HSE) and non-statutory organisations, having developed independently over time resulted in a wide variation in the services available in different parts of the country and for different needs. This coupled with the wait lists attached to clinic-based therapy services provided the context in which, in 2010, the National Progressing Disability Services for Children and Young People' Programme (PDS) was established to change the way services are provided across the country. The objectives of the programme are to ensure:

- A single, unified system of therapeutic services for children and young people.
- Equity in access to services across the country.
- Effective teams working in partnership with parent/carers.
- Resources being used optimally in a challenging fiscal environment.

The fundamental goal of the programme is to provide an integrated service model that allows children to be seen as close to their home and school as possible, with services based on need rather than diagnosis (Progressing Disability Services for Children and Young People, 2013). Furthermore, the PDS aims to develop an approach whereby health and education sectors collaborate to support children in developing their potential (Progressing Disability Services for Children and Young People, 2016).

The PDS Programme ensures that children will be seen as required by the following:

- At **Primary Care**[12] level when their needs can be met there. Primary care is all of the health or social care services in the community, outside of hospital. It includes general practitioners (GPs), public health nurses, occupational therapists, speech and language therapists, dental care, hearing specialists and psychology services.
- **Children's Disability Network Teams (CDNT)** for children with more complex needs provide specialised supports and services for children who have a disability and complex health needs associated with their disability and includes health and social care professionals (HSE, 2023).
- Specialist services with a high level of expertise in particular fields to support primary care and disability network teams.

It is important to note that children in receipt of services through the CDNTs cannot avail of services through Primary Care. However, transfer between services is possible depending on need. Children can be referred to directly to Primary Care Services or Disability Services.

Parents/guardians or personal advocates can also seek an Assessment of Need[13] which is a separate legal process set out under the Disabilty Act 2005. It is not required to access health services but will identify children's health needs and services required to meet their needs. An application can be made by a parent, legal guardian or personal advocate. There is a statutory obligation on the NCSE to nominate an appropriate person to assist the HSE as part of their AON process if education services are required. The NCSE can nominate a principal, who in turn can nominate a teacher in the school to assist in carrying out an assessment of education needs (DE, 2024g).

In February 2025, Minister Hildegarde Naughton, Minister for Minister for State Department of Children, Equality, Disability, Integration and Youth reported in the Dáil that there were 14,221 AONs overdue at the end of December 2024. Due to lengthy wait lists for CDNTs in particular, demand for AONs has increased significantly in recent years. According to Minister Naughton this increase is a reflection of both population increase and families exploring other options of support for their children, with demand for AONs 'outstripping capacity'. She further states that:

> The HSE advise that, in 2024, they received 10,690 applications, more than double the number received in 2020 (c. 4,700 applications). The current delays in accessing AONs, and the subsequent delays in receiving reports, are acknowledged, and work is ongoing by the HSE to maximise the capacity of CDNTs via recruitment campaigns and other

[12] In Limerick City, the Primary Care Centres are located in local communities and those servicing the children in Oscailt schools include Roxtown Health Centre, King's Island Primary Care Centre, Ballynanty Health Centre, Moyross Health Centre and Southill Health Centre. Children from the Northside of the City who are referred to Children's Disability Network Teams attend Blackberry Children's Services on the Dock Road while children from the Southside attend one of two teams run by St. Gabriel's Foundation – the Treehouse CDNT in Dooradoyle or the South City CDNT on the South Circular Road.

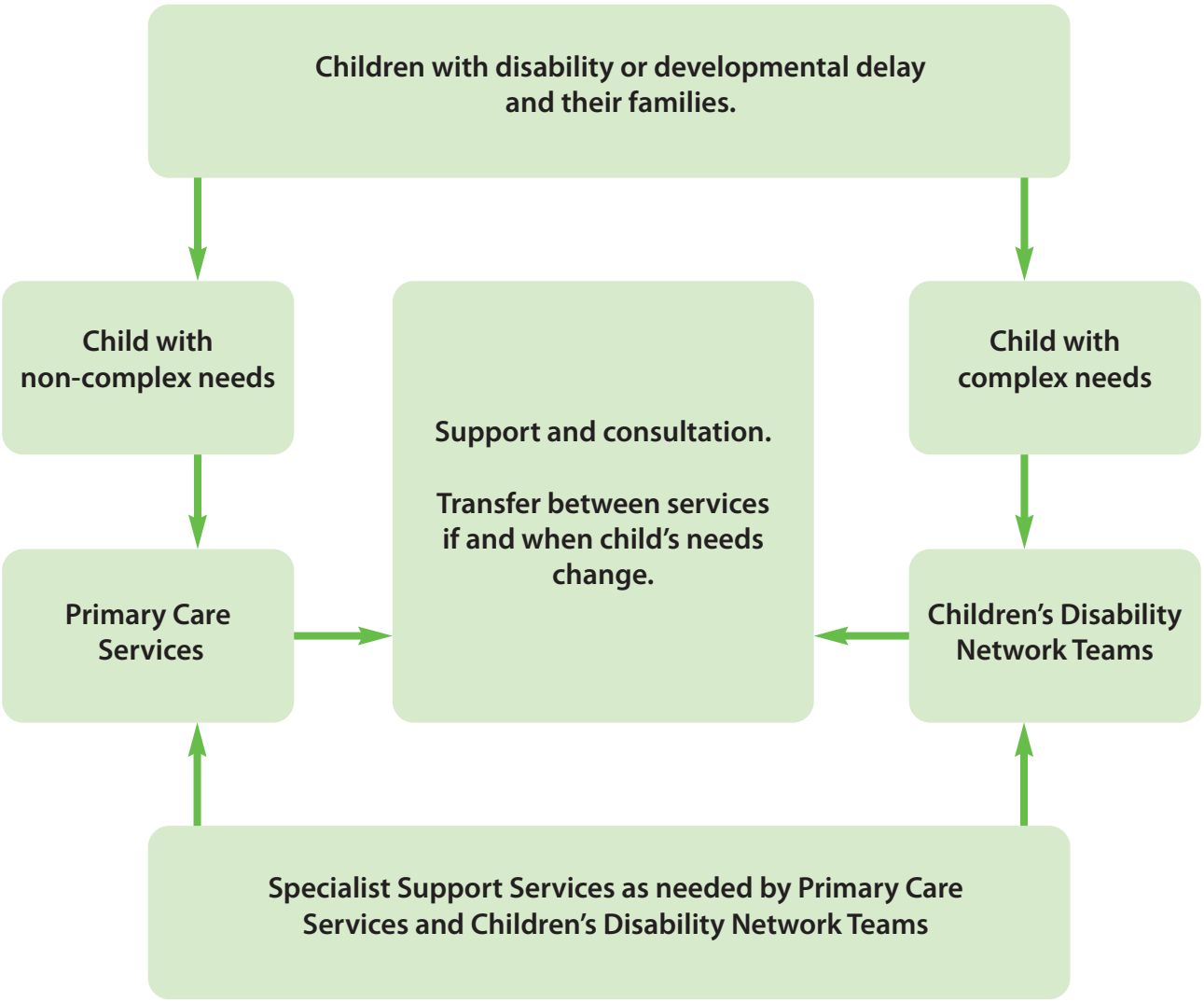
[13] A person must be born after 1st June 2002 to be assessed. A young person aged 16 or 17 years can apply for their own Assessment of Need. A team will assess the needs of the child/young person and identify their health needs. Some children will be assessed by one person. The Assessment Officer will decide whether a child needs a team assessment or an individual assessment. Parents/guardians receive an assessment report which provides information on the health and education needs of the child/young person, as well as a list of services that they need. Once an application is submitted, parents/guardians should receive a letter of confirmation within two weeks. If the Assessment Officer is satisfied that a child/young person needs an assessment they must arrange this referral within 3 months of receiving the completed application and once the referral is made there will be a further 3 months to assess the child/young person and complete the Assessment Report. In some cases, there may be a delay for clinical reasons or due to exceptional circumstances. The Assessment Officer should contact parents/guadrisan to discuss any delay in the process (For further information see https://www.hse.ie/eng/services/list/4/disability/disability-assessment/) .

measures, including sourcing assessments through private providers. Despite these challenges, a total of 4,162 AONs were completed in 2024, a 30% increase on the 3,205 completed in 2023 (Minister Naughton 2025).

It is anticipated that Regional Assessment Hubs will facilitate provision of personnel dedicated to the delivery of AON which will subsequently enable other clinical staff time to be allocated for the purposes of therapy interventions for children within the CDNT network.

While qualified health and social care professionals, across a range of disciplines, are required to improve the services available to children, it is essential to note that while there are over 45,000 children registered with CDNTs, in late 2022 there were around 700 vacant posts, or a third of all positions (Government of Ireland, 2023).

Figure 2 Progressing Disability Supports



(Source: Progressing Disability Supports 2016, p.6)

In response to a recent public consultation on the new Inclusion Framework for Health, in January 2025 the Ombudsman for Children highlighted that, in keeping with Article 24 UNCRC, as a matter of urgency Ireland must prioritise the health needs of children from marginalised backgrounds who face significant barriers to accessing healthcare:

> In Ireland, children from marginalised backgrounds, including those experiencing homelessness, from Traveller and Roma communities, or whose families are migrants or seeking international protection, often face significant barriers to accessing essential healthcare. Many of these children do not have regular access to primary healthcare providers, preventive health services, or developmental screenings, which are critical during formative years. An inclusive health approach must prioritise making these services readily available and accessible, recognising the compounded challenges these groups face, such as geographical, economic, and cultural barriers (2025, p.2).

National Educational Psychological Services

The National Educational Psychological Services (NEPS) was formally established by the then Department of Education and Science (DES) in September 1999. NEPS psychologists work with both primary and post-primary schools and are concerned with learning, behaviour, social and emotional development. NEPS psychologists work in partnership with teachers, parents and children in identifying educational needs. They offer a range of services aimed at meeting these needs including:

- Psychological support in the event of a critical incident.
- Casework support for individual children where there is a need for intensive consultation and assessment via a NEPS psychologist or through the Scheme for the Commissioning of Psychological Assessments (SCPA).
- School Staff Support and Development Service, to build school capability to provide a comprehensive continuum of support in schools.
- Ongoing access to advice and support for schools.

The focus of NEPS is on empowering teachers to intervene effectively with pupils whose needs range from mild to severe and transient to enduring (NEPS, 2024). Therefore, the NEPS model of service delivery is based on a Continuum of Support (NEPS, 2007) which provides a framework to address the needs of students, with three levels of support including Classroom Support (for all), School Support (for some) and School Support Plus (for a few). NEPS will normally be involved in a consultative and advisory capacity with pupils receiving Classroom Support and School Support and will be more likely to engage in direct work with the pupil, parents and teachers of pupils who are receiving support at School Support Plus (NEPS, 2007).

During the course of this research, it became apparent that NEPS does not maintain wait lists for assessments of individual children. Subsequently, many schools only put forward their most critical

children for support. Similarly, it was highlighted during the research that NEPS provision varies from school to school, with some schools indicating that they had not had access to a NEPS psychologist for up to three years. Instead, the schools had access to the SCPA, which is an interim measure intended to supplement the NEPS service and meet current urgent needs for psychological assessment of children and young people.

In response to a question to the Houses of the Oireachtas on 5th November 2024 regarding the number of vacant educational psychologist posts in NEPS, then Minister for Education, Norma Foley stated that there were 234 whole-time equivalent psychologists employed by NEPS across six regions. NEPS has sanction for 271 whole time equivalents posts but there have been difficulties recruiting suitably qualified staff for these posts. Since January 2023, NEPS has supported bursaries for Trainee Educational Psychologists who are enrolled in the University College Dublin Professional Doctorate in Educational Psychology and Mary Immaculate College Limerick's Professional Doctorate in Educational and Child Psychology. Those in receipt of a bursary committed to joining NEPS upon graduation. There are 74 Trainee Educational Psychologists in receipt of a bursary who are expected to join NEPS upon graduation. NEPS is also leading on the Counselling in Primary Schools Pilot. The pilot has two Strands. Strand 1 is the provision of one-to-one counselling to support a small number of children in all primary schools in counties Cavan, Laois, Leitrim, Longford, Mayo, Monaghan and Tipperary. Strand 2 of the pilot is the establishment of a new type of support to schools from Education Wellbeing Teams and the introduction of Education Wellbeing Practitioners to support clusters of schools in Cork, Carlow, Dublin 7 and Dublin 16.

Special Education Teaching Allocation Model (SETAM)

The research-based Special Education Teaching Allocation Model (Department of Education and Skills, 2017b) is a model for the allocation of special educational support teaching needs to schools based on individual schools' profiles. Under this model, the Department provides special education teaching supports directly to schools based on their educational profiles and offers schools greater autonomy to allocate teaching resources flexibly, based on students' needs rather than diagnosis. This means that students with special educational needs receive provision within an inclusive whole-school framework. According to the Department of Education, 'The key principle underpinning this revised model is that all pupils, irrespective of special educational needs, are welcomed and enabled to enrol in their local schools' (Department of Education and Skills, 2017b, p.4).

The model was further revised in 2024 (DE 2024f) so that male and female pupils are treated equally with allocation differences based on gender eliminated. The new model aims to ensure that children with complex needs get the support they deserve in a timely fashion as school-level data from standardised tests will be used to allocate special education teaching hours. This means that children will no longer have to wait to be assessed by the HSE. A unique educational profile is now created for every school based on the following three pillars:

1 The total enrolment in the school.
2 The Educational Teaching Needs Profile –based on the STEN scores for English/Irish and Maths reported by the school.
3 Educational Disadvantage – the key data source is the Pobal HP Index for Small Areas, which is a method of identifying the relative affluence or disadvantage of a particular geographical area (DE, 2024f).

The removal of complex needs from the profiling criteria is problematic and many believe that it will negatively impact on provision and may result in reduced levels of inclusion in mainstream schools (Mannion, 2025). This is in direct contrast to the NCSEs (2024) policy advice in 'An Inclusive Education for An Inclusive Society: Policy Paper on Special Schools and Classes'. The NCSE use the category of complex needs as a rationale for its advice to continue the current multi-track system of provision using special classes and special schools to provide support for students with complex needs as part of its progressive realisation of an Inclusive Education System (NCSE, 2024).

School Inclusion Model

Launched in 2018 by the NCSE, the School Inclusion Model (SIM), which seeks to build schools' capacity to include students with additional care needs, made a broader range of support options available so that students would have access to the right support at the right time delivered by the appropriate professionals (NCSE, 2018). The SIM featured a number of elements that may impact inclusion in Irish schools with children no longer needing a formal diagnosis to receive additional support in school. The features included an In-School and Early Years Therapy Support Demonstration Project (explored under the review of models of support in Ireland), a nurse-led service for students with complex medical needs, development of NEPS and ten regional support teams with specialist teachers, SENOs, speech and language therapists, occupational therapists and behaviour experts working to support schools and parents (NCSE, 2018).

Educational Therapy Support Service

In June 2024, then Minister for Education Norma Foley, TD and Minister for Special Education and Inclusion Hildegarde Naughton, TD announced the establishment of an Educational Therapy Support Service (ETSS), which will provide the NCSE with the opportunity to build on the achievements and impacts of the School Inclusion Model pilot programme (Department of Education, 2024c).

The ETSS will permanently appoint occupational therapists, speech and language therapists, and behaviour practitioners to the NCSE. These therapists will collaborate with teachers in classrooms to design and implement educational interventions for students with various needs. This SIM model is designed to promote the participation and inclusion of all students in primary and post-primary settings – particularly those with special education needs – with a multi-tiered system of support, providing individualised or intensive educational support for students with the greatest level of need. For instance, an occupational therapist might work with a teacher to incorporate more movement into lessons to aid

regulation, or a speech and language therapist could demonstrate effective vocabulary strategies in the classroom.

The speech and language, as well as occupational therapists, will be integrated into the NCSE's regional teams. They will also collaborate with school communities, NCSE colleagues, and, when appropriate, professionals from NEPS and the Health Service Executive (HSE).

The ETSS aims to allow the NCSE to work synergistically with health services, including primary care and disability teams, to address systemic issues in providing therapeutic supports for children and young people. In 2025, the ETSS is being expanded to include schools from Limerick and Tipperary.

Counselling in Primary Schools Pilot (CPS-P) 2023-2025

In May 2023 the Minister for Education announced a programme of counselling support which is being piloted until 2025 in primary schools in counties Cavan, Laois, Leitrim, Longford, Mayo, Monaghan and Tipperary (DE, 2023). In October 2024 it was announced that this pilot was extended to 61 urban DEIS primary schools in the clusters of Dublin Southwest and North Dublin City (DE, 2024e). The decision to extend the pilot to the 61 DEIS schools in the area mentioned above is in response to the aforementioned OECD review (OECD, 2024). The report highlighted the negative impact of social deprivation on wellbeing and educational outcomes and recommended the enhancement of the capacity of DEIS schools to meet the needs of the most disadvantaged communities with the extension of this pilot being one such measure.

Some of the key points of the pilot including the following details (DE, 2024):

- The programme is designed as a supplementary measure on an interim basis to existing HSE Primary Care Psychology and CAMHS services. Furthermore, it does not replace the role of NEPS within schools.
- NEPS will have responsibility for establishing county panels of pre-approved counsellors who will provide in-person counselling support to schools (online counselling or office-based sessions are prohibited under this programme).
- Participating schools will be allocated blocks of up to eight counselling sessions. Each block consists of eight counselling sessions with six of these sessions being one-to-one with the pupil and the remaining two being consultative sessions with parents/guardians and school staff.
- Each participating school will establish a link person (such as the principal) who will be the point-of-contact. Further responsibilities of this link person are to manage and arrange parental consent and referrals to the counsellor and to provide the counsellor with relevant school policies and procedures (e.g. Child Safeguarding Statement, Behaviour Policy, Anti-Bullying Policy).

Programme for Government 2025

The 2025 Programme for Government (Government of Ireland, 2025, p. 69) commits under 'Education' to

creating a dedicated National Therapy Service in Education commencing with special schools. In recognition of recruitment difficulties and shortage of qualified therapists, it aims to:

- Double the number of college places for speech and language therapists, physiotherapists, occupational therapists, educational psychologists and any other specialists required.
- Create new expedited qualification routes for professionals with relevant skills and experience.
- Examine the provision of funding supports for those seeking to upskill into therapy programmes.
- Provide therapy assistant posts within the education sector to maximise therapists' ability to deliver bespoke therapy services.
- Ensure that the model of therapy provision allows children in SEN classes and mainstream to access essential therapies, in addition to those in special schools.
- Additionally, work with relevant stakeholders to collect data to create more targeted, effective
- services for children with special needs.

Under the section 'Disability' (ibid, pp.92-93), the Programme for Government also commits to helping children to get the therapies they need. It recognises that wait lists for Assessment of Need are 'far too long' and subsequent impact on children and families. Specifically, the document states that the government will:

- Increase staffing, train more therapists and prioritise children's disability teams to deliver supports and services.
- Support families who are waiting too long for an Assessment of Need to procure assessments privately.
- Reform the Disability Act 2005 in consultation with stakeholders.
- Create a dedicated National Therapy Service in Education, beginning with special schools.
- Complete the review of the EPSEN Act and make sure that it meets the needs of children with special educational needs.
- Increase the number of Regional Assessment Hubs.
- Establish an annual Children's Therapies Grant Fund to provide evidence-based therapies

Further commitments are set out under 'Child and Youth Mental Health' (ibid, p. 95) that are relevant to this report. Here, the government indicates it will:

- Legislate to regulate CAMHS.
- Continue to expand the central referral mechanism to simplify referrals to community paediatric services, including CAMHS, to ensure that no child is placed on the wrong waiting list.
- Continue to resource CAMHS teams to reduce wait lists.
- Establish targeted supports for children with autism experiencing mental health challenges.

- Develop a new care model for HSE Primary Care Psychology to expedite services for young people with less complex issues.
- Enhance youth mental health services for those up to age 25, focusing on smoother transitions from CAMHS to adult mental health services.
- Increase staffing in under-18 dual diagnosis services to better treat young people with mental health and substance abuse issues.
- Continue to invest in waiting list initiatives.
- Launch the Youth Mental Health app to support the mental health needs of young people.

International models of integrated support

The Community School Model in the US

There are many definitions of the Community School in the literature but fundamentally, they all share the premise that children can only learn when their basic needs are met. Community schools therefore endeavour to tackle contemporary issues that inhibit a child's learning (Dryfoos, 2002). Gomez et al. (2012, p.28) describe Community Schools not as a programme but 'a way of doing business – a collaborative approach to supporting children's success' thus acting as 'a full-spectrum resource for families and children'.

Community Schools share a common set of principles (Blank et al., 2003; Klevan et al., 2023) and thus often include the following key characteristics:

- Integrated systems of support including mental and physical healthcare
- Opportunities for extended learning, both during and outside of regular school hours and beyond the school calendar
- Active involvement of family and community
- Fostering of strong partnerships
- Setting of high expectations for all

All Community Schools have a full-time coordinator to supervise the coordination of services between agencies with services offered not only to students but to parents and community members alike. Community Schools address the mental health, dental health and general health needs of families onsite in schools and often serve as the hub of their neighbourhood (Caldas et al., 2019). Significantly, Community Schools are directed at children who face the most challenges throughout their school experience but acknowledge that policies and social and economic structures are at the root of inequality rather than the children and families themselves (Heers et al., 2016). The evidence suggests that community schools may improve students' academic readiness and close the achievement gap by addressing barriers to learning (Anderson-Butcher et al., 2008).

City Connects

The City Connects (CCNX) Programme was developed over 20 years ago and is implemented in over 160 schools across 40 U.S. cities and towns and in ten schools in the NEIC, Dublin. In the 2022-2023 school year, nearly 50,000 students were served (City Connects, 2024). The evidence-based programme, operated by Boston College is premised on the fact that educational attainment is impacted by poverty. CCNX is a school-based intervention that addresses the needs of students in schools in marginalised communities and families and improves outcomes for children by building a network of support for them, their families, and the schools that serve them.

The National Centre City Connects Ireland (NCCCI) was established in May 2024 in the Curriculum Development Unit (CDU), Mary Immaculate College (MIC), Limerick and is a partnership between Boston College, Mary Immaculate College, the Department of Education and Tusla.

In September 2020, as part of a comprehensive government initiative addressing poverty and intergenerational disadvantage in Dublin's NEIC, two distinct projects were launched in the 10 NEIC primary schools, acknowledging the interconnected nature of their efforts. These two projects are the CCNX Pilot Project and the in-school NEIC Multidisciplinary Team (MDT). The NEIC MDT is looked at later in the review.

The CCNX Pilot Programme in the North East Inner City (NEIC), Dublin, Ireland has been implemented since 2020 and is a strategic response to identifying the needs, strengths and interests of children and matching them with appropriate services in the community in a timely manner. Multidisciplinary collaboration is a strong feature of CCNX and is a critical component of identifying and successfully supporting children's strengths and needs.

CCNX has been rigorously evaluated over time in the U.S. and outcomes that have been identified for children include better performance on standardised tests and lower rates of absenteeism with the children less likely to become early school leavers. A number of reports on implementation in Ireland have been completed to date (Bourke et al., 2021; Bourke and Lyne, 2022; Lyne et al., 2023 and Bourke, 2025).

Student Welfare Services Finland

The Pupil and Student Welfare Act was introduced in Finland in 2014 to ensure that every school and educational institution has qualified social work and school psychologist services available. Pupil and student welfare focuses mainly on prevention and benefits the entire school community. However, students are also entitled to personalized support, designed to assist their learning, health, wellbeing, and sense of inclusion. It is based on systematic multi-professional cooperation between teaching staff, health and social services as well as any other actors deemed necessary (Vainikainen et al., 2015; Kivimaki et al., 2018).

The Partnering for Change Model

The Partnering for Change (P4C) model is an innovative, collaborative school-based service delivery model which was initially developed for occupational therapists working in Ontario schools. P4C focuses on needs-based intervention for children with motor coordination challenges, although its application has broadened to support children with diverse needs.

The key features of the P4C Model include:

1. **Partnerships:** Occupational therapists work closely with teachers, parents and school staff to identify and address students' needs within the classroom environment.
2. **Capacity building:** Occupational therapists, parents and educators learn from each other thus ensuring enhanced capacity to support children's participation both in school and at home.
3. **Tiered service delivery**: Evidence-based information and strategies are used to provide a tiered service delivery framework with services delivered (a) universally for all students, (b) via differentiated instruction for smaller groups of learners and (c) through intensive interventions as required.
4. **Early identification and prevention:** When families and educators become more knowledgeable, issues that the child is dealing with can be identified sooner and accommodations provided earlier. This proactive approach helps mitigate more complex potential issues.
5. **Contextual Support:** Therapists have a consistent presence in schools thus providing support in-context where students learn and participate.

The P4C model represents a shift from traditional pull-out OT services to a more integrated, collaborative approach within schools. This focus on capacity building, tiered service delivery and early intervention supports a more inclusive educational environment (Missiuna et al., 2012). For further information see: https://www.canchild.ca/en/research-in-practice/current-studies/partnering-for-change

The Australian School-Based Integrated Health Care Model

The Australian School-Based Integrated Health Care (SIH) Model is designed to provide comprehensive school-based health services that target the emotional, physical, developmental and educational needs of the child. This model involves multidisciplinary collaboration between existing service providers from the local area including psychologists, occupational therapists, speech and language therapists and others. This collaboration creates a supportive environment that promotes student wellbeing and academic success (Mendoza Diaz et al., 2021). Key components of this model include:

1. **Accessible Health Services:** Health services are made readily accessible to students within the school, reducing barriers to care such as transportation and cost, creating an avenue to reduce inequality. The onsite provision of services also reduces disruption in children's attendance at school.

2 **Holistic Approach:** Health professionals work together with educators and other health professionals to manage health concerns in a comprehensive and timely manner while recognising that physical, mental, and emotional wellbeing are interconnected.
3 **Coordination:** The SIH usually has a coordinator whose role it is to shepherd families through the different services offered, thus navigating the bureaucracies often rooted in health and education systems, which can often be overwhelming for families in vulnerable positions.
4 **Connection:** A sense of connection is fostered between the health and education staff and the families, creating a supportive network for children in the context of their family and social circumstances.
5 **Early Intervention and Prevention:** The model emphasises early identification of health issues and timely intervention to prevent more serious problems (Mendoza Diaz et al., 2021; Rungan et al., 2024).

Irish models of in-school therapy support

School-Based Speech and Language Therapy Pilot Project

In the years 2005-2006, following a review of the high level of ongoing non-attendance at Speech and Language Therapy (SLT) appointments in some of the designated disadvantaged areas of Limerick City, it became clear that clinic-based service provision was not adequate to meet the needs of the people in those areas (O'Connor et al., 2012). It was thus agreed that that the SLT Department, HSE, would deliver a school-based SLT pilot programme, which was evaluated by the TED Project, MIC. The study showed that children attended school-based therapy more regularly than they had clinic-based therapy, with parents acknowledging the ease of attendance at school-based appointments due to familiarity with and ease of access to the environment.

There was also increased effectiveness in the use of the therapists' time. When children were absent, their appointment was filled by another child in the school thus session time was not wasted. The pilot project identified increased collaboration between therapists and teachers thereby enabling teachers to work more effectively with the children with regard to their speech and language needs. Similarly, therapist's knowledge of the curriculum was enhanced. Importantly, pre- and post-therapy assessments showed evidence of progress for many of the children in the area of speech and language development with 29 out of 34 children (85%) progressing to a less severe diagnosis (O'Connor et al., 2012). Furthermore, the study showed that it is more cost effective to provide school-based services both during the period of intervention but also, when a child receives early intervention, it is likely that they will require less additional services at a later date. Following the pilot project, it was recommended that for any future school-based SLT service it would be important to ensure that adequate accommodation be available in the participating schools while the need for Continuing Professional Development for teachers in participating schools was stressed.

In-School and Early Years Therapy Support Demonstration Project

In 2016, 'A Programme for a Partnership Government' (Government of Ireland, 2016) acknowledged that providing earlier access to speech and language therapy services could make a vital difference to children's future opportunities and promised the introduction of a new in-school speech and language service creating stronger linkages between parents, teachers and SLTs. In this context, funding was provided by the then Department of Education and Skills (DES) to set up a Demonstration Project in the 2018/2019 school year (Lynch et al., 2020) as a pilot for the SIM (cited earlier). The focus of the project was initially the provision of an in-school speech and language therapy service but was subsequently extended to include occupational therapy service provision and additional funding was provided by the former Department of Children and Youth Affairs (DCYA) to include Early Learning and Care (ELC) settings. As an inter-agency partnership with the HSE, the Demonstration Project aimed to develop and test a tiered model for the delivery of therapy support across 150 targeted ELC, primary, post-primary and special school settings in the HSE Community Healthcare Organisation, Region 7 (Dublin West, Dublin South West, Dublin South City and Kildare/West Wicklow).

The project also aimed to recruit a team of 31 speech and language therapists and occupational therapists to work alongside an inter-agency management team to:

- develop and evaluate a multi-tiered continuum of therapy service delivery
- explore models of effective inter-agency collaboration with education staff
- demonstrate optimal use of resources between therapists delivering services to schools and ELC settings and existing services available to children and families.

The tiered continuum of therapy support was modelled on an internationally recognised and evidence-based model of:

- tiered support for all children in a whole-school setting at Tier 1
- targeted support for those at risk at Tier 2
- and intensive, individual support for those with an identified need at Tier 3.

A recruitment framework was quickly established in partnership with the HSE that facilitated the rapid recruitment of skilled, experienced (averaging 9.3 years of relevant service) speech and language therapists and occupational therapists who then engaged in a bespoke induction programme.
The project was successful during its first year in the implementation of an in-school continuum of therapy support in 150 schools and ELCs, serving more than 27,678 children onsite at their schools or ELCs. Of the total number of therapy interventions, 71% were Tier 1 interventions which included 169 staff training and CPD interventions and 123 whole-class inclusion initiatives. Additionally, 13% of the therapy interventions were Tier 2 interventions which focused on supporting groups of children identified as at-risk and 16% were Tier 3 interventions whereby therapists delivered 167 one-to-one therapy interventions for individual children within their schools or ELCs.

The Demonstration Project prioritised the building of relationships and the establishment of collaborative practices, thus ensuring a high level of direct and indirect contact between project therapists and staff at participating settings. An evaluation of the project (Lynch et al., 2020) reported that staff enjoyed more confidence and ability in the early identification of children with inclusion needs, were more adept at modifying classroom environments and teaching strategies and developed a greater understanding of the therapist's role in supporting all children in education. Similarly, survey data emphasised a number of positive outcomes including increased academic engagement, increased positive classroom interactions, increases in positive social interactions for children and increased differentiated instruction. In addition, data from interviews highlighted the fact that children who had heretofore been considered 'hard to reach' were identified and supported as a result of the provision of therapy services onsite in the participating venues. Educators and staff at participating schools and ELCs responded positively to the introduction of in-school, tiered therapy services with 93% of them recommending the continuation or expansion of in-school therapy services as proposed in this project.

The Demonstration Project faced a number of challenges, however. The inter-agency management model led to issues with the management and supervision of individual therapists while the multi-agency nature of the key project participants led to duplication in recording information and highlighted the need to adhere to data management standards such as general data protection regulation (GDPR). While it succeeded in delivering comprehensive, peer-led induction opportunities with rapid knowledge and skill development for therapy staff at the outset, the induction programme system was deemed unsustainable and did not provide an equitable platform for knowledge and skill development for staff recruited later on in the project. The need for ongoing CPD was also noted.

Significant time was spent at the early stages of the project enhancing the education staff's understanding of the nature of tiered service delivery. Furthermore, the tiered model of service delivery was deployed on a phased basis, which resulted in a delay to the implementation of Tier 2 and Tier 3 interventions until after January 2019. Thus, a fully operational multi-tier continuum of therapy was only put in place at a late stage of the project and limited the time available for evaluation of the model.
It is essential to note that while approximately 10% of the student numbers in the participating venues were identified as having education and/or inclusion needs such that they warranted therapy services, 91% of these would not have had access to speech and language therapy or occupational therapy services without the Demonstration Project.

The newly established Educational Therapy Support Service (ETSS) (explored earlier in this review), is intended to enhance the achievements and impacts of the Demonstration Project.

The North East Inner City Multidisciplinary Team, Dublin

In September 2020, as part of a whole government response to poverty and intergenerational disadvantage in the North East Inner City of Dublin two discrete projects commenced in the 10 NEIC primary schools, with recognition that the work of the two projects would be interconnected (Department of

Education, 2024c). These two projects are the City Connects Pilot Project (see below) and the in-school North East Inner City Multidisciplinary Team (NEIC MDT).

The NEIC MDT is an interagency collaboration between the HSE and the Department of Education comprising of educational psychologists from NEPS and HSE speech and language therapists, occupational therapists and a psychologist. The NEIC MDT works with ten primary schools in Dublin's North East Inner City across the disciplines of Occupational Therapy, Speech and Language Therapy and Psychology and works with all children, though with a particular focus on children with additional needs. The NEIC MDT provides a comprehensive, child-focused, tiered approach that addresses presenting needs through evidence-based interventions and promotes best practices to positively impact the lives of children, their parents, and the school community (DE, 2023). Due to early identification of positive impacts in school attendance, calmer classrooms and greater teacher confidence to support children with special education needs, it was mainstreamed by the HSE and Department of Education (Fahy, 2024). Some of the key features of the NEIC MDT model include the following (DE, 2024b):

- A commitment to the development of academic, social, emotional, communication and independent living skills for all children.
- The provision of a professional school based and child-centred service in a timely manner.
- A response to the presenting needs of the child with evidence-based assessment and intervention through a tiered model of support.
- Advising and training parents and school staff.
- Collaboration between school staff and other professionals to identify needs and intervene with appropriate teaching approaches thereby improving outcomes for all children.
- Support for the development of inclusive practices in schools and the promotion of wellbeing for all children, staff and families.

Models of in-school support in Oscailt schools

The Health Alliances for Practice-Based Professional Education and Engagement (HAPPEE) Project

The HAPPEE project is a pilot project co-funded by Limerick Regeneration and the University of Limerick (UL). It was first piloted in 2020 and 2021 in Corpus Christi Primary School, Moyross and was expanded to five more schools in September 2023. The project has been designed to improve outcomes for children and families living in the Regeneration communities of Limerick by facilitating UL students from the disciplines of physiotherapy, speech and language therapy and occupational therapy to complete their professional placements in six participating schools.

The students provide therapy supports to the pupils and schools with professional supervision from staff of St. Gabriel's Foundation[14], using a multi-tiered model of therapy support as per best practice. Children attending schools the six schools in Limerick Regeneration communities were selected to

[14] St. Gabriel's Foundation is a not-for-profit organisation and registered charity that provides services to children with disabilities and their families through two Children's Disability Network Teams, Hydrotherapy, Orthotics and a Children's Respite House.

participate in the pilot project as they have a history of difficulty accessing health services in the traditional clinic-based model.

A key component of the programme is the interprofessional collaboration between disciplines to provide a more holistic approach to healthcare in a setting with which the children are familiar and trust. In a report on the HAPPEE Project, Hickey (2025a) notes that the HAPPEE Project takes a multidisciplinary approach to nurturing emotional well-being, enhancing skill development, and fostering community engagement, thereby empowering children to excel both academically and personally. The project achieves significant developmental milestones, enhancing verbal skills, independence, and social interactions through a tailored, gradual therapeutic approach that empowers children to overcome challenges at their own pace. Children demonstrated significant growth in confidence, skill acquisition, and emotional regulation through their participation in the project (Hickey, 2025a).

The HAPPEE project effectively addresses a longstanding service gap for children with additional needs, providing timely interventions and promoting inclusion. It seamlessly integrates therapy into the school environment, offering families unmatched convenience while maintaining children's routines and fostering a stable, supportive setting for therapy. As a result, children's attendance at school-based appointments reached 98%, highlighting the effectiveness of providing services in a familiar and accessible school environment (Hickey, 2025a).

The HAPPEE Project also offers UL students a unique, community-centred paediatric experience that fosters professional growth, autonomy, and essential skills while providing a holistic understanding of paediatric interventions through collaboration with children, school staff, and health professionals (Hickey, 2025a).

While the HAPPEE Project faces challenges such as resource limitations and sustainability concerns, it presents a unique opportunity to reshape education and therapy practices. Through its innovative interventions, measurable outcomes, and strong collaborative focus, the initiative serves as a scalable model with the potential to benefit schools and communities nationwide. To ensure its continued success and expansion, strategic investment, ongoing research, and greater professional engagement will be crucial. Beyond addressing immediate needs, the HAPPEE Project paves the way for a future where education, therapy, and inclusion seamlessly converge to support every child's potential (Hickey, 2025a). For further information see: https://www.ul.ie/engage/node/7651.

The Sky is the Limit Family Centre, Moyross

Corpus Christi Primary School in Moyross, Limerick has independently adopted a whole-school wrap around model approach to supporting their children and families. *The Sky is the Limit* programme delivers a range of therapeutic and family support services at a newly built and philanthropically funded integrated service centre on site – the Corpus Christi Family Centre CLG (Hickey, 2025b). It is coordinated by the Clinical Care Team, consisting of a Senior Clinical Psychologist, the chairperson of the Board

of Management, the school principal, an assistant psychologist, the deputy principal, the HSCL Coordinator, Community Companion and the family support worker. They meet weekly to assess referrals from staff and parents/carers and to decide on appropriate school-based supports for the child or family involved. The Care Team is led by a clinical psychologist who also supervises the trainee and pre-accredited psychotherapy programme.

The school embodies many of the characteristics of the US model of the Community School (explored earlier in the review) including enriched and expanded learning during and outside of school hours, active family and community engagement and collaborative leadership practices that include various stakeholders in decision-making (Klevan et al., 2023). Its community focus ensures that all community members are welcome on campus, thereby fostering a sense of belonging and support.

In a report on *The Sky is the Limit,* Hickey (2025b) established that it functions as a strategic, intergenerational holistic, school-based program, fostering overall well-being by addressing not only academic and cognitive needs but also emotional, social, psychological, physical, and spiritual aspects. *The Sky is the Limit* model is multidisciplinary in that it embraces a number of disciplines including Psychology, Play Therapy, Music Therapy, and Psychotherapy. As they are part of the HAPPEE Project (explored earlier), the school also provides speech and language therapy, physiotherapy and occupational therapy onsite for children.

The Sky is the Limit fosters a positive school environment where children feel safe, supported, and valued, promoting a sense of belonging and active participation. By providing a secure space for expression and personal growth, it empowers children to build resilience, develop coping skills, and confidently navigate challenges (Hickey, 2025b). *The Sky is the Limit* empowers parents and carers by providing school-based therapeutic support, practical assistance, and access to essential resources (such as housing and employment support), strengthening family well-being and resilience. Through dedicated initiatives that foster trust between parents/carers, school staff, and external agencies, *The Sky is the Limit* enhances parental engagement and creates a more supportive school experience (Hickey, 2025b).

The success of *The Sky is the Limit* is based in part on the strong, trust-based relationships it fosters among children, staff, parents/carers, and partner agencies. Built on mutual respect and collaboration, these connections enhance the effectiveness of support services and initiatives. Onsite access to a range of services is highly valued by staff and parents/carers, as it removes barriers like time, stress, and cost. This convenience enhances accessibility to therapeutic support, increasing the likelihood of families seeking and receiving the help they need (Hickey, 2025b).

The theoretical frameworks on which *The Sky is the Limit* programme is based are Bronfenbrenner's Ecological Systems Theory (1979) and the Power Threat Meaning Framework (PTMF) (Boyle and Johnstone, 2020). Bronfenbrenner's theory identifies five interrelated environmental systems that influence a child's development thus acknowledging that it is not only the school that impacts a child's

learning. It was that which led to the holistic wrap-around model of the programme and the array of services it provides which include after-school programmes, play and music therapy for the children, psychotherapy for parents/carers and an intergenerational mindfulness programme along with housing and employment support.

The PTMF offers an alternative to the traditional medical model of psychiatric diagnosis. In contrast, the PTMF borrows from the trauma-informed approach to emotional distress and a belief that distress can be understood as a meaningful response to challenging life experiences (Aherne et al., 2019).

Summary

This literature review highlights the vital importance of school-based therapy services in enhancing the inclusion and social participation of all children in educational settings. Multidisciplinary collaboration emerges as a key element in addressing the complex needs of students while the benefits of school-based multidisciplinary collaboration are manifold, both for students and professionals. However, the review also identifies significant barriers, including mismatched expectations, communication challenges, and resource limitations, which can hinder effective collaboration. In Ireland, there have been several promising initiatives introduced by government in recent years, but expansion and mainstreaming has been a slow process in a national context of significant needs for multidisciplinary services and lengthy wait lists. Locally, for DEIS schools in Limerick Regeneration communities, initiatives have developed in response to local needs and to provide early intervention due to lengthy wait lists and delays in accessing statutory services. These initiatives recognise the key role that DEIS schools can play in overcoming the challenges associated with clinic-based services.

In sum, the transition towards school-based therapy services and multidisciplinary collaboration is essential for creating inclusive educational environments. Continued efforts to address barriers and promote effective models of service delivery will be crucial in maximising the potential for all children to participate fully and equally in their educational journeys.

Section 4

Methodology

Research aims

The aim of this research was to establish the level of need for onsite multidisciplinary support in Oscailt school in order to improve the overall quality of life, mental health and wellbeing of the students who attend the schools. The research also sought to identify the number and type of supports required and to ascertain how multidisciplinary supports might best be delivered to children from Regeneration communities in local schools.

Hearing the voices of children, parents, school staff and multidisciplinary staff was imperative to fully understand needs in relation to multidisciplinary support. McTavish et al. (2012, p.251) confirm the importance of including the voice of research participants, in particular the child stating that 'research methods not only provide opportunities for children to express themselves but are also a potential source for empowering children in decision-making processes that affect them'.

Research methodology

This study adopted a mixed methods approach (Creswell and Plano Clark, 2007; Dunning et al., 2008; Creswell, 2014), which allows for topics to be explored in greater depth than using a quantitative or qualitative approach in isolation (Gelling, 2014). The study included:

1 A literature review that outlined the benefits and challenges of in-school multidisciplinary support and examined national, international and local models of multidisciplinary support onsite in schools.
2 A review of relevant education and health policy and legislation to understand the background to and development of multidisciplinary services in Ireland and the national context that impacts on the provision of multidisciplinary support services.
3 An online survey for school principals, teachers, Special Needs Assistants (SNAs) and multidisciplinary staff which acted as a needs analysis and scoping tool about the delivery of multidisciplinary support onsite in all the participating schools. This was developed in consultation with Oscailt principal representatives and piloted in advance. Based on their knowledge, experience and perception of students' needs, principal and staff survey respondents were asked to identify whether None, A Few, Some, Many or All/Most students had needs in a range of areas. A detailed list was provided in the surveys. For reporting purposes, these are grouped as follows:

- **Individual student needs** - Emotional and Behavioural, English as an Additional Language, Intellectual, Mental Health, Physical Ability, Social Skills and Speech and Language Therapy.
- **Family Context** – Addiction, Death of Parent or Family Member, Domestic Violence, Homelessness, Housing Issues, Mental Health of Parent/Carer, Parent/Carer with Special Educational Needs, Separation/Divorce/ Single-Parent Family.

- **Attendance** – Leaving school premises early unaccompanied without permission, Linked to Education Welfare Officer (EWO)[15], Poor attendance but not linked to EWO, Punctuality, School Refusal.
- **Other needs** – Clothing, Community Context (needs arising from inequalities in the community, e.g., community violence, lack of services, etc.), General Health, Living in Care, Nutrition, Substance abuse (by student).

  Principal and staff survey respondents were also asked to asked indicate how many of their students they believe needed to avail of particular services and how many were linked to these same services. These included:
- **Mental health services** – Creative therapies, Limerick Social Services Centre Therapy, CAMHS, Jigsaw, Psychotherapy, Substance abuse/misuse and Pieta House.
- **Education services** – NEPS, exemption from Irish, Limerick Youth Service, Assistive Technology grant, Visiting Teacher Service.
- **Other services** – Family support services, diasbility services, housing services, CARI, and other.

4 Focus groups with children, school staff and multidisciplinary staff about their experience of and perceptions about multidisciplinary support onsite in schools. Focus groups with children explored their experiences at school including what makes their school day more/less enjoyable and what makes it easier/more difficult to learn. The Lundy Model of Participation (DCYA, 2015) was adopted, which recognises children's right to participate in decision making affecting their lives. The key focus is to ensure that children have the space to express their views; their voice is enabled; they have an audience for their views; and their views will have influence.

5 Interviews with principals and parents to elicit the perceived multidisciplinary and other needs of the students attending the participating schools.

6 Photovoice was used to engage 3 children across 3 different schools. Please see below for an overview of the photovoice method adopted.

The benefit of multiple methods and sources of data is triangulation of findings and enhanced overall validity, credibility and reliability of the research (Robson 2011; Creswell 2014). Ethical clearance was granted by Mary Immaculate College Research Ethics Committee (MIREC) for this research on 10th November 2023.

Data Collection Timeframe and Source

Table 11 provides an overview of the data collected for this research which commenced in December 2023 and was completed in May 2024. Primary data was collected through surveys with principals, school staff and multidisciplinary professionals; interviews with parents and principals; and focus groups with children, school staff and multidisciplinary professionals.

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[15] Education Welfare Officers (EWOs) work for Tusla Education Support Services (TESS) and are based throughout the country to offer advice and guidance to parents who need support in ensuring that their child attends schools regularly. Schools make referrals to the EWO if they are concerned about attendance. The EWO works with the school and family. Home visits are an essential part of an EWO's work and the first meeting with an EWO very often opens up a pathway of solutions for a child and family needing support. Once problems have been identified the EWO will work with those involved to improve the situation for the child/young person. For further information see https://www.tusla.ie/tess/information-for-parents-and-guardians-tess/education-welfare-service/how-does-the-educational-welfare-service-work/

Purposive sampling was used to recruit research participants (Robson 2011; Miles et al. 2014). All schools in the Oscailt network were made aware of the research and principals/Chair of the Board were sent a letter to invite schools to participate. An invitation to participate and link to a Principal Survey was then circulated via Qualtrics to the Oscailt network contact list. An invitation to participate and link to a Staff Survey on Qualtrics was circulated to Oscailt principals, who then emailed same to all their school staff. An invitation to participate and link to a Multidisciplinary Staff Survey on Qualtrics was emailed to principals to send to multidisciplinary professionals delivering services in their school and to members of the research advisory group to circulate to multidisciplinary professionals in their respective organisations. With their permission, principals shared contact details of relevant staff (e.g., HSCLs, Teachers, SNAs) who were willing to participate in interviews and focus groups with the researchers. Children were selected by school staff to participate in focus groups on the basis of experience or needing multidisciplinary support and their parents were asked permission for them to participate in focus groups or Photovoice study as appropriate. Following parental permission, children were then asked for their permission to participate in the research. Relevant parents were invited to participate in focus groups and interviews through the Home School Community Liaison Coordinators. All research participants were provided with detailed Information Leaflets and Consent Forms and made aware of the benefits and risk of the research and their right to withdraw from the research at any stage without consequence. Child friendly Information and Consent Forms were made available for children and explained to them by the researchers in advance of data collection. All interviews and focus groups were recorded with participant consent and transcribed.

Following data collection, anonymised synopses of key points raised were emailed to principals and parents/guardians who participated in interviews and school staff and multidisciplinary professionals that participated in focus groups to give them the opportunity to verify by email, phone call or anonymously by post, whether the synopsis included their perspectives, to clarify interpretation by the researcher and to suggest amendments.

Table 11 Data collection

Timeframe	Data Collection Technique and Source
Dec 2023 – Mar 2024	Qualtrics Surveys (N=11, Principals; N=181, School Staff from 13 schools)
Jan 2024-May 2024	Qualtrics Surveys (N=28, Multidisciplinary professionals)
Jan 2024-Feb 2024	Individual Interviews (N=12, Principals; N=12, Parents)
Feb 2024-Mar 2024	10 Focus Groups (N=41, Children)12 Focus Groups (N=40, School Staff)
April -May 2024	Photovoice (N=3, Children)
April -May 2024	2 Focus Groups (N= 7, Multidisciplinary Professionals)

Photovoice

Photovoice is a participatory research method that focuses on the use of participant led photography as the basis for discussing participants' experiences and opinions (Cluley, 2016). **Table 12** details the process adopted which involved discussion with the children of photographs they took of the things they like about school and the things they would like to change. Photovoice can empower participants to express their needs and provides researchers with valuable insights into their perspectives (Wang and Burris 1997). This method is particularly beneficial for vulnerable populations including children, as it reduces the reliance on literacy and verbal communication skills. Booth and Booth (2003) emphasis its suitability for individuals with intellectual disabilities, aiding those who struggle with direct communication or cognitive challenges. A primary objective of photovoice is to enable participants to document and reflect on their lives, thereby giving them a platform to advocate for improvements in their living conditions (Overmars-Marx et al, 2018; Mannion et al., 2024).

Three Oscailt schools agreed to participate in Photovoice, one of which offered onsite multidisciplinary support. One student from each of three schools was invited by their principal to participate in the research after consent was given by parents. Two of the children had Special Educational Needs. All three children had experienced multidisciplinary support, either onsite in the school or in another setting. Photovoice in this context included four meetings with the children as detailed in Table 12 below:

Table 12 Photovoice Process

Meeting	Action
One	• Informed students of the process • Sought assent from the students to take part • Chatted with the students to find out their name, age, year/class • Discussed research questions with the students e.g., What do I like about school? What would make school better? • Provided rules and guidance around taking photographs for student and SNA e.g., No faces to be included in the photographs; photos cannot be shared or uploaded to social media; photos taken only when SNA is present; iPad stored in a locked press in school when not in use) • Provided prompts of photos to be taken (e.g., The places I like to go in school; the things I like to do in school; the things that make me happy in school; places in school that I'd like to change; things in school that I'd like to change)
Two	• Re-sought assent from the student to take part • This meeting with the students took place after the photographs had been taken • Discussed the student's experience of taking the photographs • Photo elicitation interview: discussed photographs to elicit the meaning of each photograph

	• Photographs were used as prompts for the students to describe their experiences • The student signed a photo release form
Three	• Re-sought assent from the student to take part • Used the photos to create themes with the students that told their story • Created a visual presentation of their story with the students
Four	• Re-sought assent from the student to take part • Students made a presentation to members of the school community as decided upon by the children. The presentation displayed some of their photos using a medium of their choosing, e.g., PowerPoint presentation or poster

Ethical Considerations

For the Photovoice method, participating students had access to a school iPad to store data (their photographs). The iPads were the property of the school, were password protected and encrypted and did not allow access to the internet. They were used only by the participating student and were stored in a locked press in the school for the duration of the process. Permission for researchers to use the photos taken by the students were sought by the researchers and the photos were then downloaded onto a password protected college laptop via a USB cable. All data was wiped from the iPads after the photos were saved by the researcher. Audio recordings of the photo-elicitation sessions were destroyed once they were put onto a password protected college laptop and made anonymous.

Data Analysis

The photos were thematically coded with each participant during the third meeting. They were later reviewed with the accompanying narratives and reflections to gain a greater understanding of the content and context.

Analytic Strategy

The researchers adopted Creswell 's (2014, pp. 197-201) six-step general process for qualitative data analysis. Interview and focus groups transcripts were reviewed for accuracy and familiarisation and subsequently coded using QSR Nvivo 12. The themes were developed deductively based on the specific research questions and inductively based on themes emerging from participants' accounts. A synopsis of key points raised by each group of interviewees and focus groups participants was compiled for the member check process and shared with the relevant group for feedback and to check interpretation. Presentations were also made to the Oscailt and PLUS Networks to elicit feedback on draft research findings. The narrative account presented in the findings is informed by the same. Quantitative data from surveys with principals, school staff and multidisciplinary professionals was analysed using Microsoft Excel and charts and tables were developed to display the data visually.

Recommendations and conclusions made in this report are grounded in the data collected and presented in the final section of the report. The analytic approach outlined enabled the researchers to check the plausibility of the research findings and conclusions through the recursive process of refinement and verification of themes in the data. It also supported examination of 'negative evidence' (Miles et al., 2014, p. 259), seeking counterfactual or negative cases from within the data, or through collection of additional data, in order to disconfirm the researcher's initial assumptions about what is going on and counter researcher bias (Robson, 2011).

Limitations of the research

While the research gave primacy to the perspectives of children, parents, school staff, and multi-disciplinary professionals, the perspectives of those in statutory agencies with responsibility for decision making regarding allocation of resources were not included due to the parameters of the research.

The research team included individuals who have worked with Oscailt schools for a long period of time, have established working relationships with principals, HSCLs and other staff through TED work and who have previously conducted research on TED initiatives. To help reduce researcher bias and participant reactivity, the researcher who circulated surveys, contacted prospective research participants, and conducted interviews and focus groups was only working on this research project and less familiar with Oscailt school staff. The member check process also helped to reduce researcher bias.

In addition to multidisciplinary support where it is available onsite in schools, consideration must be given to the wide range of supports available for students in Oscailt schools through the DEIS programme and other initiatives, such as those detailed in the literature review. This research was not evaluating student outcomes in relation to multidisciplinary support or other initiatives or interventions but rather garnering perspectives on levels of need for multidisciplinary support and how it might be delivered in Oscailt schools into the future.

Overview of survey participants

Principals

All Oscailt principals were given information letters and consent forms and asked for permission for this research to be conducted in their school with permission given by 12 principals. In December 2023, these 12 principals were emailed directly via Qualtrics with the principal survey and 11 completed the survey, 1 post-primary and 10 primary principals.

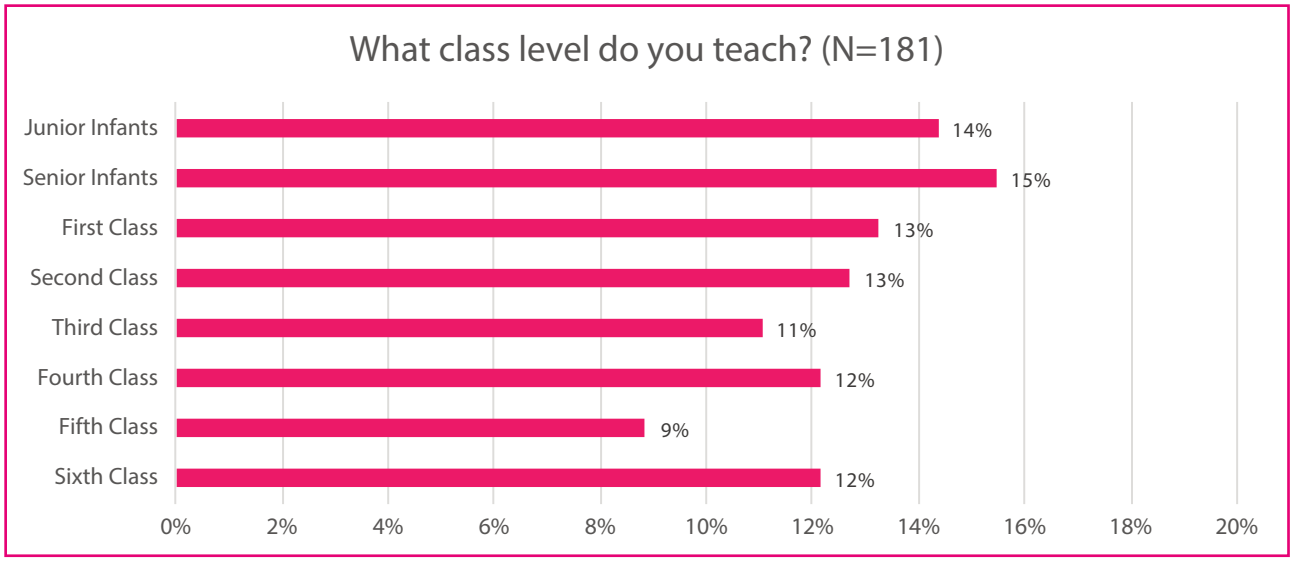
School Staff

A link to school staff surveys was emailed to principals to circulate to school staff. Despite only 12 schools giving permission to conduct research in their school, a total of 181 staff across 13 schools completed the survey. Given that school staff could only have accessed the survey via the link sent directly to them by their principal, we included survey responses from all 13 schools. Based on staffing numbers of 391.5 (298 Teachers and 93.5 SNAs) reported by 11 principals in the principal surveys, the response rate for school staff surveys is 46%. However, this is not accurate as the staff responses were from 13 schools and the exact rate would be lower.

Of the 181 staff survey respondents, 86% (N=155) indicated they were in a teaching or Guidance Counsellor role, followed by 10% (N=19) in the role of Special Needs Assistant (SNAs) and finally 4 % (N=7) were Home School Community Liaison Coordinators (HSCLs). Of staff who responded to the question about whether they work in primary or post-post-primary (N=154), 91% (N=138) work in primary schools with the remaining 9% (N=16) working in post-primary settings.

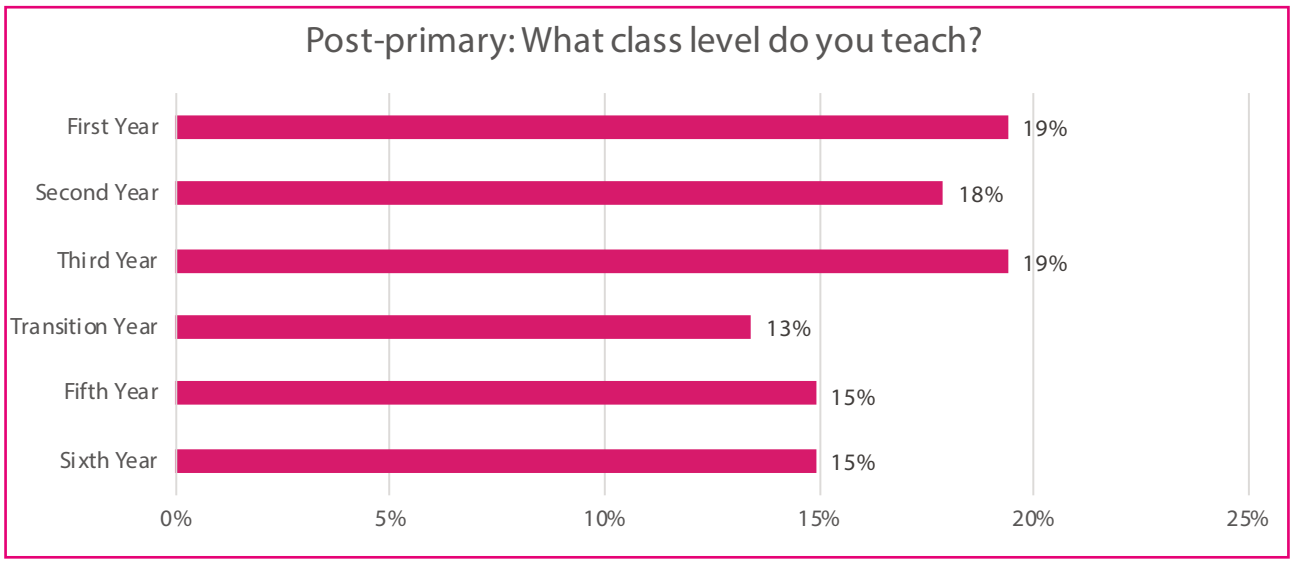
At primary level, the greatest number of respondents (15%, N=28) worked with Senior Infants, followed by Junior Infants (14%, N=26), First class and Second class at 13% (N=24), Fourth and Sixth class (12%, N=22), Third class (11%, N=20) and finally Fifth class (9%, N=16).

Chart 1 Staff survey respondents at primary level and class



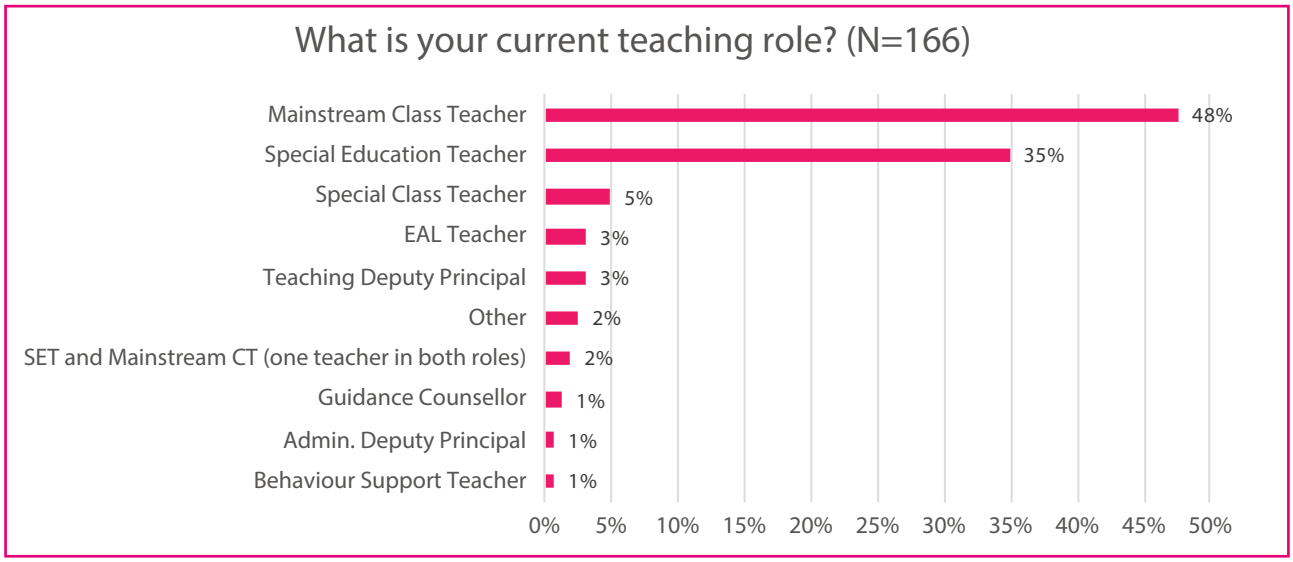
At post-primary, where teachers work across year groups, the majority of respondents work with both First (19%, N=13) and Third years (19%, N=13), followed by Second (18%, N=12), Fifth and Sixth years (15%, N=10) and finally, Transition year students (13%, N=9).

Chart 2 Staff survey respondents at post-primary level and year



Of those respondents who were in a teaching role, the majority (48%, N=79) were mainstream class teachers, followed by Special Education Teachers (35%, N=58) and Special Class Teachers (5%, N=8). The remaining respondents were EAL teachers, Teaching Deputy Principals, job sharing roles, Guidance Counsellors, Administrative Deputy Principal and Behaviour Support Teacher respectively. A small percentage (2.4%, N=4) of respondents identified in the other category which included an Early Start Teacher, a Programme Coordinator and a Deputy Principal.

Chart 3 Staff survey respondents teaching role



Multidisciplinary Professionals

Of the 28 multidisciplinary professional survey respondents, the majority (32 %, N=9) identified as 'Other'. Professions identified within this category included nurses, a public health consultant and doctor, a social worker, a manager and an early intervention educator. A further 14% (N=4) indicated they were a Physiotherapist, with the same number indicating they were an Occupational Therapist (14%, N=4). This was followed by Art Therapist (11%, N=3), Speech and Language Therapist (7%, N= 2) and Psychotherapist (7%, N=2). Finally, with each at 4% (N=1), the remaining respondents were from a Music Therapist, Adult and Child Psychologist, Consultant Psychiatrist and Educational Psychologist.

Chart 4 Multidisciplinary professional survey respondents and role

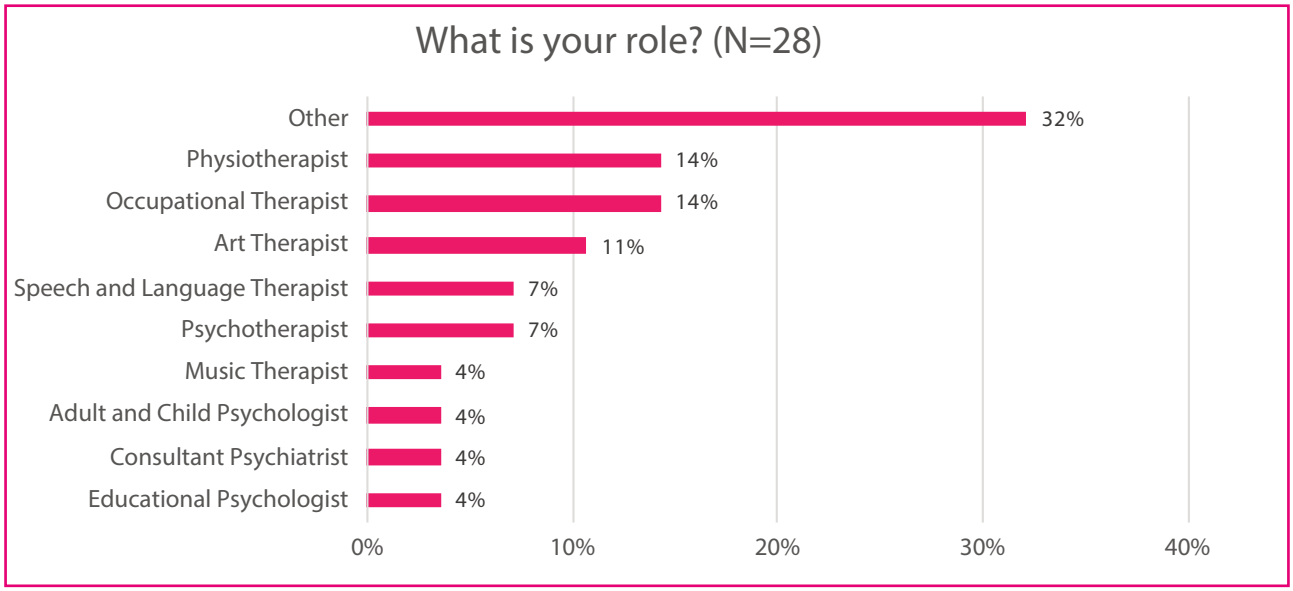
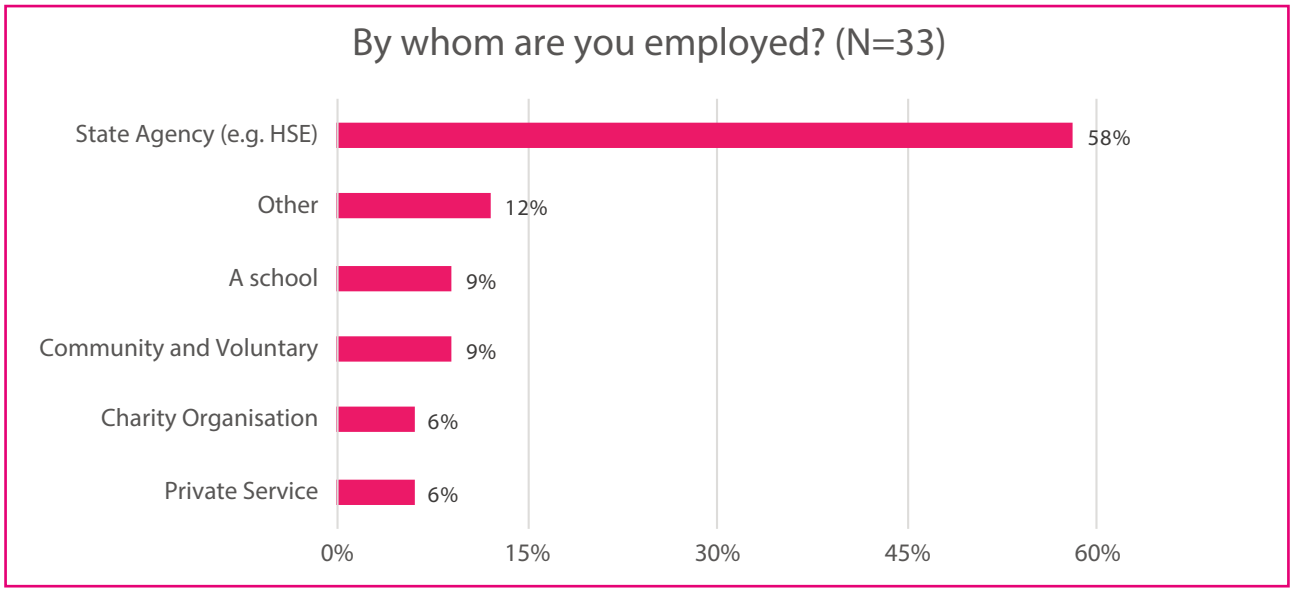


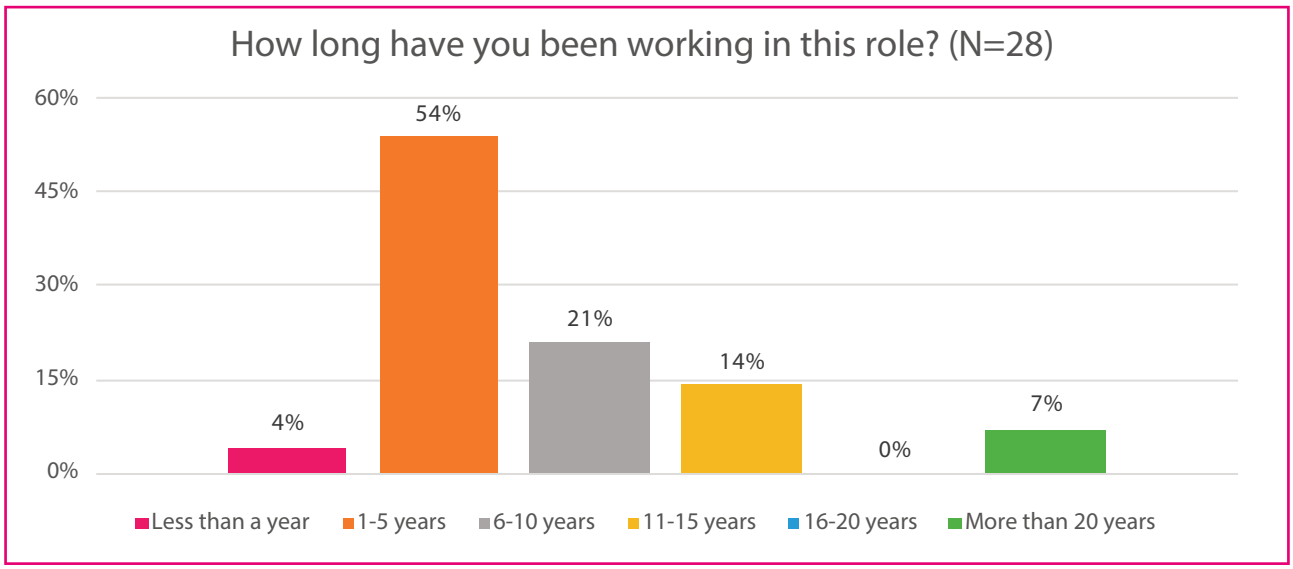
Chart 5 shows that of the 28 multidisciplinary professional survey respondents, the majority (32 %, N=9) identified as 'Other'. Professions identified within this category included Nurse, Public Health Consultant, Doctor, Social Worker, Manager and an Early Intervention Educator. A further 14% (N=4) indicated they were a Physiotherapist, with the same number indicating they were an Occupational Therapist (14%, N=4). This was followed by Art Therapist (11%, N=3), Speech and Language Therapist (7%, N= 2) and Psychotherapist (7%, N=2). Finally, with each at 4% (N=1), there remaining respondents were from a Music Therapist, Adult and Child Psychologist, Consultant Psychiatrist and Educational Psychologist.

Chart 5 Multidisciplinary professional survey respondents and employer



When asked how long they had been in their role, over half (54%, N=15) had between 1 and 5 years' experience. This was followed by 6-10 years' experience (21%, N=6), 11-15 years (14%, N=4) and 2 respondents (7%) had over 20 years' experience. Finally, one respondent had less than a year's experience in their role.

Chart 6 Multidisciplinary professional survey respondents' length of experience



Section 5

Findings

The aim of this research was to document the level of need for multidisciplinary support in the Oscailt schools that participated, to identify the types and quantity of multidisciplinary support already provided in schools and to provide guidance on how multidisciplinary support might be delivered in Oscailt schools into the future.

To respond to these aims, the findings have been divided into three sections:

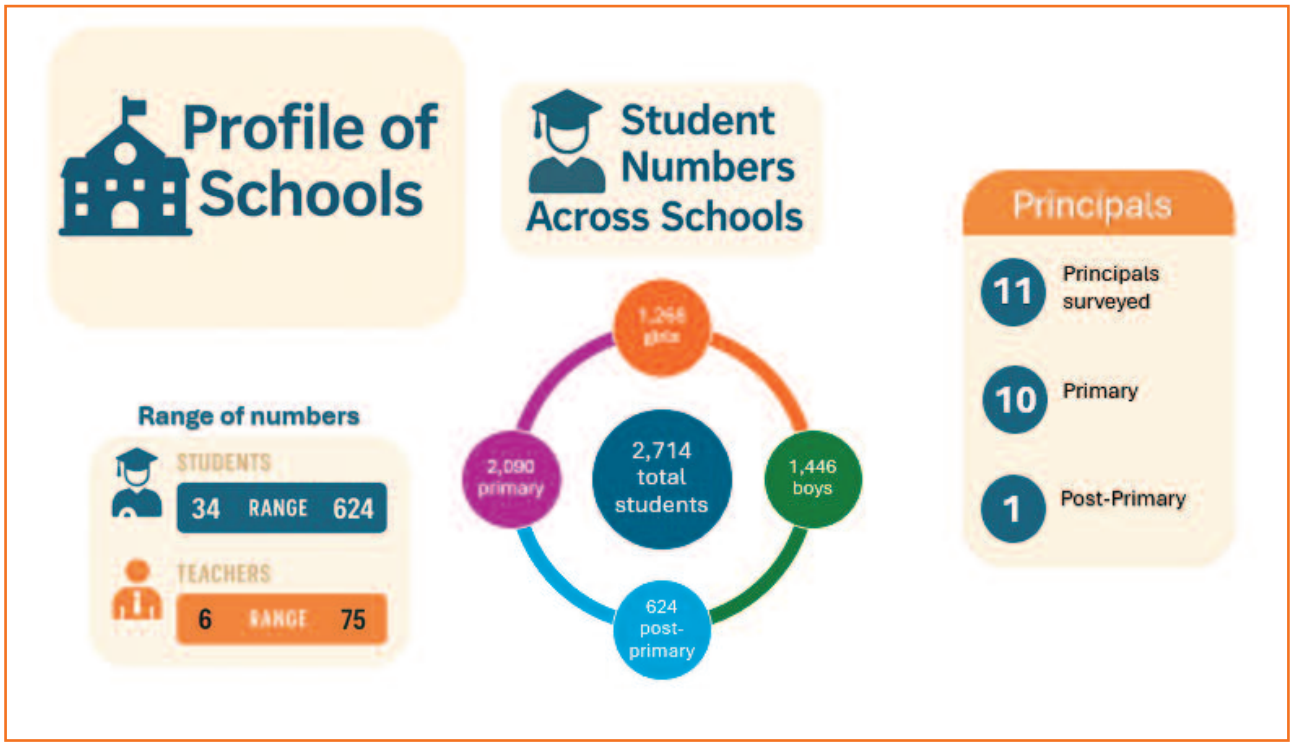
1. **Understanding the schools involved in the research** – This section provides an overview of the schools that participated in the research and details the interests, strengths and needs of children as identified by research participants. Subsequently, the section delineates the critical role participating schools play in meeting children's non-academic needs, services required to meet children's needs and presents findings on the significant support that schools provide for parents.
2. **Current onsite support and referral pathways –** This section presents findings on the level of existing multidisciplinary supports provided onsite in participating schools, the current referral pathways for multidisciplinary supports both on and off-site and outlines barriers experienced by children and parents in accessing same.
3. **A more nuanced understanding of onsite multidisciplinary support** – The final section details findings in relation to the benefits of onsite multidisciplinary for children, parents and school staff as well as the challenges posed by same. Finally, this section outlines key considerations identified across participant accounts for the ongoing/future delivery of multidisciplinary support in Oscailt schools.

Part 1 - Understanding the schools involved in the research

Profile of Schools

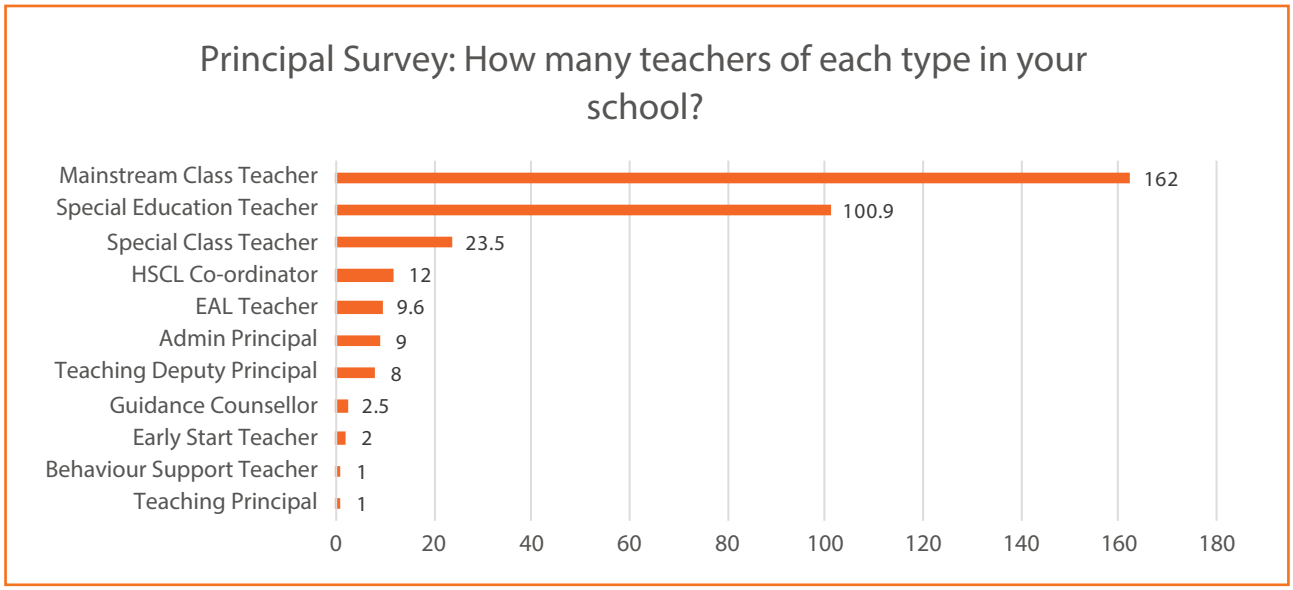
As detailed in **Figure 3 Profile of Schools**, eleven principals, ten primary and one post-primary, completed surveys providing detailed information on the number of students in schools and the observed needs of students. Schools ranged in size from 34 to 624 students and the number of teachers ranged from 6 to 75. A total of 2,714 students were recorded by principals at the time of survey, 1,268 girls and 1,446 boys. A total of 624 students were post-primary, with the remaining 2,090 attending primary. Detailed charts are not included to retain anonymity of schools involved.

Figure 3 Profile of Schools



Principal surveys indicate that while the majority of teachers in the 11 schools were mainstream class teachers (49%, N=162) approximately 30% (N=100.9) were Special Education Teachers.

Chart 7 Principal survey - number and type of teachers



The number of Special Needs Assistants in schools, according to principals, ranged from 4.5 to 11.5.

Children's strengths and needs

Children's strengths

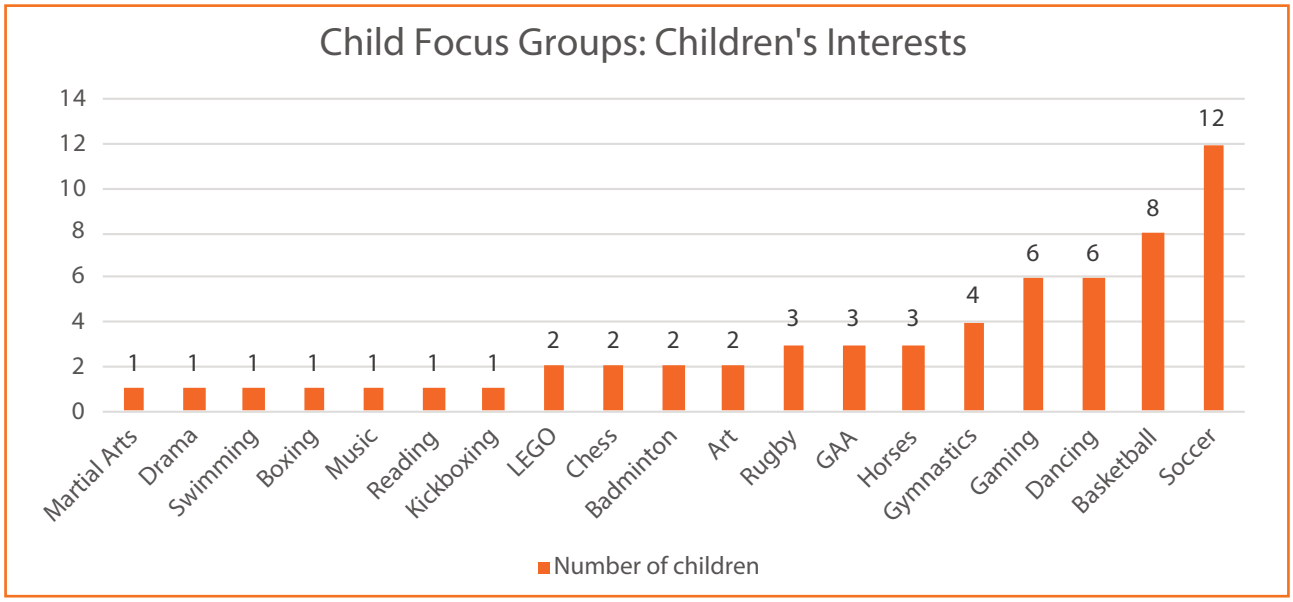
In principal interviews and staff focus groups, participants identified a range of strengths of children across schools including:

- Some schools are very diverse and have many nationalities, cultures and traditions represented amongst students. This was perceived as creating a *'better learning'* environment for children in the school as well as fostering *'acceptance and kindness'* towards new students and a sense of community. Some students also act as translators within the school for parents/family members.
- Diversity within the school community in terms of LGBTQ+ was highlighted by one post-primary principal.
- Students were described as *'very enthusiastic', 'warm-hearted', 'kind'*, *'mannerly'*, well behaved and happy in school with strong, trusting relationships with staff and other students. Principals highlighted that students are *'very appreciative'* of schools and staff.
- Some children may have *'traumatic'* backgrounds but were described as *'very resilient'*, appearing to be happy in school, and trusting of the school and the staff who work there, which helps to create a strong sense of community. Additionally, staff in one post-primary school relayed that due to the openness of students and trust in staff, students are very willing to seek help from support staff e.g., Counsellors, if they need it.
- Staff in some schools described children as being *'very dynamic', 'very active', 'very hands on'* and having great interest in the environment and animals. One participant shared that their school was *'not a chalk and talk kind of school'* (Teacher School 11). Students' interest in sports were identified as a key strength by some schools.

Children's interests

A wide variety of children's interests and activities were identified by research participants. **Chart 8** shows that soccer, basketball, gaming, dancing and gymnastics were the top 5 areas of interest as identified by child focus group participants.

Chart 8 Children's interests



Parents, school staff and principals also highlighted a variety of children's interests including an interest in their local community, sports, dance, musical activities, art, animals, and STEM activities.

- Sports – soccer, boxing, GAA, hurling, hockey, rugby, kickboxing, badminton, basketball, swimming, cricket
- Musical activities – singing, choir, Peace Proms, orchestra, tin whistle
- Dance, stage school, gymnastics
- Animals – horses and dogs
- Board games/LEGO – chess, LEGO
- Creative arts – art, drawing, speech and drama, Junk Kouture
- STEM – science, ICT, coding, electronics, Beebots, robotics, YouTube, gaming
- Debating
- Baking and cooking
- Messy play
- Book club

Staff focus group participants indicated that some schools provide a variety of after school activities in these areas in addition to opportunities to try activities as part of the curriculum. Principals shared that, in some schools, staff volunteer to provide these clubs and activities after school. Both principal interview and staff focus group respondents highlighted a lack of clubs and facilities for children's activities in the locality as well as barriers of cost and transport for children's participation in activities. Additionally, child focus group participants indicated that they did not always get to participate in the activities they are interested in. One school indicated their intention to do a survey with children in the next school year to ascertain their interests.

Children's needs

Principals and staff focus groups participants identified a wide variety of needs amongst children, both diagnosed and undiagnosed. Many of these were prevalent in most schools. This conveys the complexity of these classroom and school contexts.

Individual student needs identified included educational and developmental needs such as EAL, literacy and numeracy needs, afterschool support, medical needs, physical ability e.g., motor skills, social skills and speech and language needs. Some primary principals identified *'foundation'* needs in junior infants due to low uptake of early childhood services e.g., structure and routine and motor skills.

Every school emphasised emotional and behavioural needs, support for regulation and psychological and mental health needs. Social anxiety and school refusal were also highlighted by some schools.

> *'My top priority would be CAMHS, psychological issues, mental health issues because I think that's the greatest priority if a child is struggling with their well-being or their mental health, they can't focus on anything else'* (Principal 1).

Post-primary schools highlighted self-harm and suicidal ideation as particular concerns in relation to mental health, with one relaying that they had a *'watch list'* for students who may be suicidal. At post-primary level, specialised support for sexual assault and trauma was identified as an urgent need due to lengthy wait lists.

> *'I think it is an absolute disgrace that we have 12 and 13-year-olds who've been seriously sexually assaulted, that are waiting a year and a half to talk to someone'* (Principal).[16]

Principals and school staff focus group participants highlighted needs in relation to specific conditions such as Autism, ADHD, Developmental Coordination Disorder/Dyspraxia or learning differences/difficulties such as dyslexia.

> *'So, we see a variety of complexities with the children presented. We've children with autism diagnosis in our ASD classes and then we have about five or six in the mainstream as well with Autism diagnosis. We've seen a huge increase in with the children come up with complex needs around DCD, an increase in children presenting with dyscalculia, dyslexia. And then we have children, they would have low cognitive ability as well'* (Principal 11).

Some principals identified additional needs within the Travelling community arising from trauma and in some cases, low parental levels of education.

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[16] ***Participant code not used to retain anonymity.***

Other individual student needs identified across schools included nutrition and hygiene, the need for structure and routine, organisational skills, the need for consistent adults in children's lives, sensory needs and children with needs arising from Adverse Childhood Experiences (ACEs), trauma or from experiencing racism.

> *'Structure, routine, a caring adult that actually will follow through on something you know. That you notice if something is amiss, "You have no coat today, can we sort you a coat for tomorrow?". You know those kinds of basics, that someone who actually really cares, and doesn't just leave it go. …whether it's food, whether it be hygiene, whether it be clothing, they're met daily here for some children'* (Teacher[17] School 3).

Post-primary schools highlighted how needs can arise on the transfer from primary due to the different structure and scale of post-primary schools e.g., moving around, managing your locker and books. Further needs arise due to the gap in levels of support some feeder primary schools can provide for children, which the limited resources of post-primary schools cannot match. School staff also relayed the limited capacity of staff and other supports e.g., School Completion Programme, to respond to the complex variety and level of needs.

> *'There's a lot of trauma within every class and there's an awful lot of trauma that kids have experienced, and services like play therapy, art therapy, music therapy are stuff that are really needed in this school. That would be number one. There's a huge amount with speech and language again, the physio, the OT and we're constantly referring, like within every class there's referrals to primary care but what we're finding is that primary care don't have the resources, CAMHS don't have the resources either to meet the needs'* (Teacher School 6).

> *'I'd say there are very few children in the classes who wouldn't have at least two or more ACEs. You know it would be very high need, a lot of trauma, other generational trauma from poverty and housing issues to unemployment to the newly arrived students who are coming from the war-torn countries or they're seeking some form of a better life. But they bring with them all their trauma. Then they bring that to school because they don't have anywhere else to bring it'* (Teacher School 4).

The impact of COVID was highlighted with staff in one school stressing an increase in percentages of children that need assessments from NEPS or CAMHS. Lengthy wait lists, delays in referrals and delivery of services have resulted in children being developmentally below their age academically as they were not picked up earlier. Principals relayed concerns about missing out on developmental checks on children's language development and literacy:

[17] *Teacher is used to refer to all school staff focus group members.*

> *'The legacy of COVID has been horrific, maybe 60 or 70% of the children have expressive and receptive language needs you know and now they are in second class, there was a dent in their experience'* (Principal 5).

Additionally, wait lists for services were reported to have been worsened by COVID which in turn have exacerbated children's needs where *'instant and immediate support'* (Principal 6) is required.

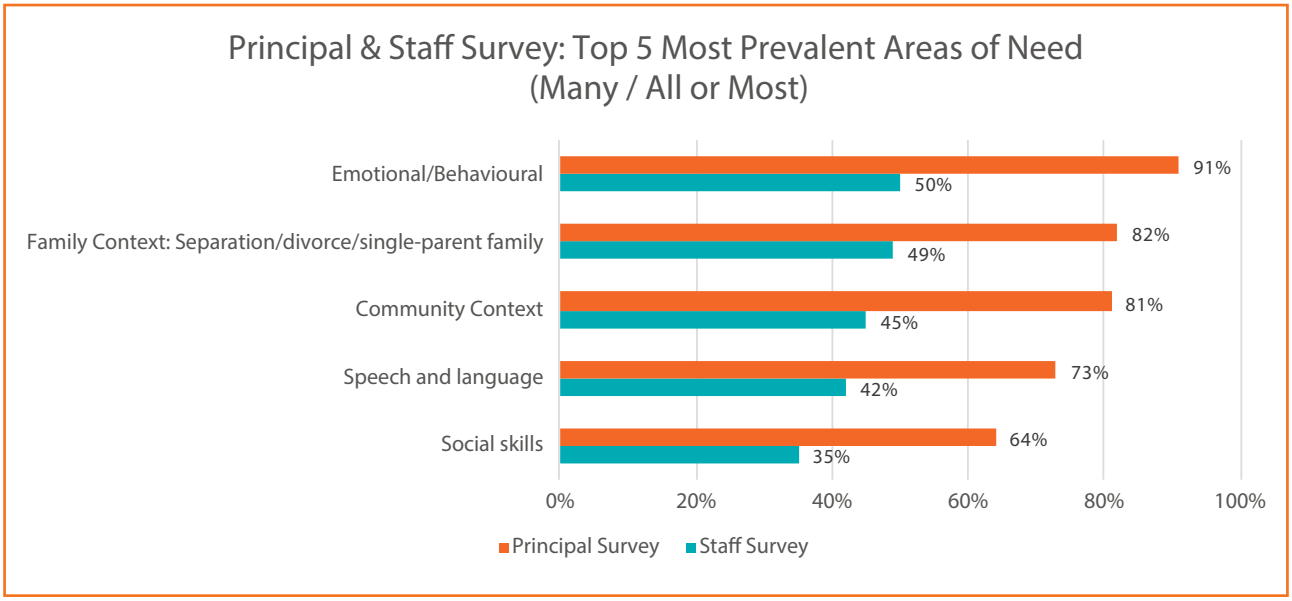
Family context needs identified included families struggling, families in homeless accommodation, lack of financial resources and poverty, lack of stability, structure, routine and caring adults in children's lives. Community context needs highlighted included socio-economic disadvantage, lack of resources/facilities in the locality and lack of safe places to play outdoors.

Survey responses on students' needs

As detailed in Section Four, principals and staff survey respondents were asked whether students had needs in a range of areas.

Chart 9 below details the top 5 most prevalent areas of need identified by survey participants when the 'Many/All or Most' response options are combined. Principals and staff identified Emotional/Behavioural needs as the most prevalent need, followed by Family Context: Separation/Divorce/Single-Parent Family, Community Context needs (arising from inequalities in the community, e.g., community violence, lack of services, etc.), Speech and Language needs and finally, Social Skills.

Chart 9 Top 5 most prevalent areas of need amongst students



Overall, principals tended to give higher ratings of 'Many/All or Most' than staff survey respondents, which displayed greater distribution across all five response options. It is important to note here that principals responded to the questions about perceived student needs and engagement with services based on all the students in the school, whereas teachers, HSCLs and SNAs may have been responding in relation to children in a particular class or classes or, in the case of HSCLs, their target group of families. In some instances, principals are not able to share information with staff about individual children due to GDPR so staff awareness of sensitive issues may be lower. The greater variation in staff survey responses may also be due to the far greater number of responses from staff.

Individual student needs

When 'Many/All or Most' are combined, **Chart 10** shows that principals ranked student individual needs in the following order: 1. Emotional/Behavioural (91%), 2. Speech and Language (73%), 3. Social Skills (64%), 4. Intellectual (54%) and 5. EAL (36%). These were followed by 6. Mental Health (Some/Many 81%) and 7. Physical Ability (54%).

Chart 10 Principal ranking of individual student needs

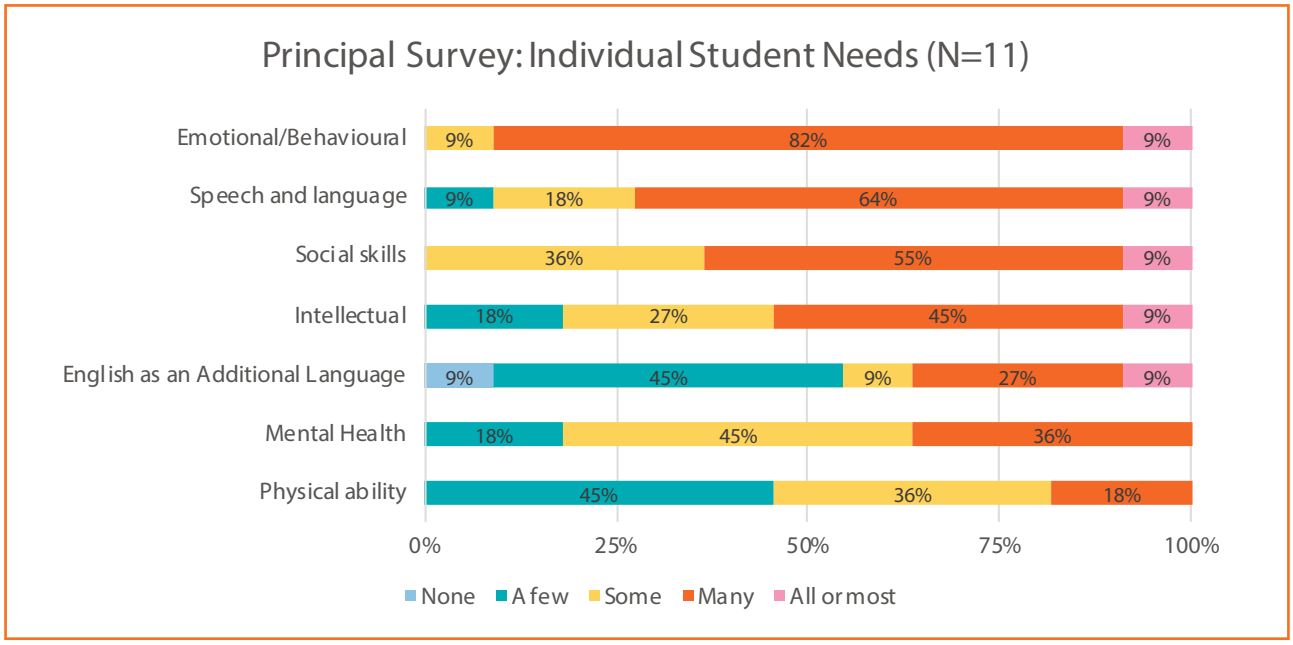
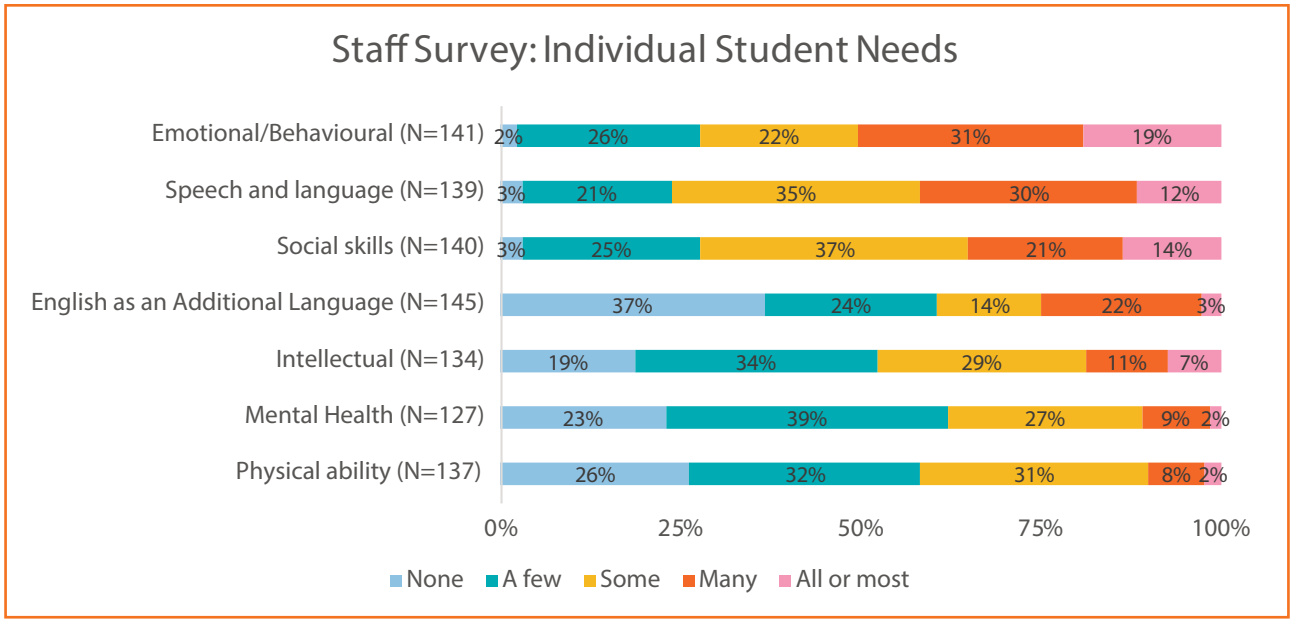


Chart 11 shows that staff also identified 1. Emotional/Behavioural needs (Many/All or Most, 50%), 2. Speech and Language (41%) and 3. Social Skills (35%) as the most prevalent needs amongst their students but differed in placing EAL fourth (25%) before 5. Intellectual (18%), 6. Mental Health (11%) and 7. Physical Ability (10%) needs.

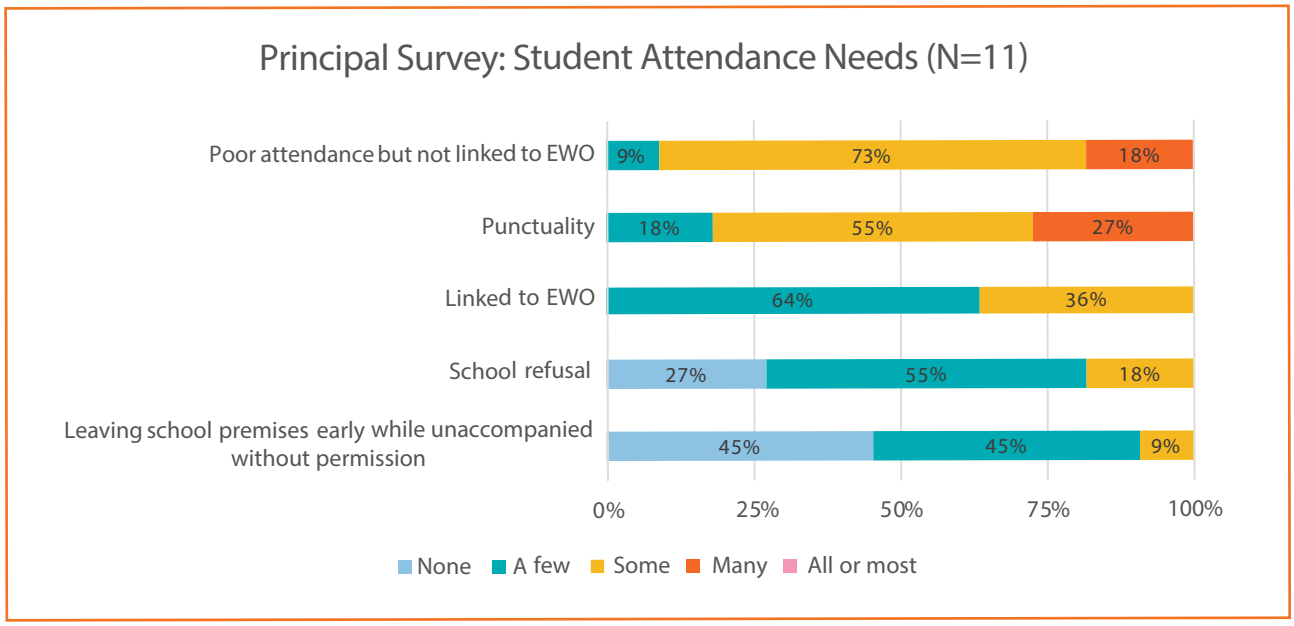
Chart 11 School staff ranking of individual student needs



School Attendance needs

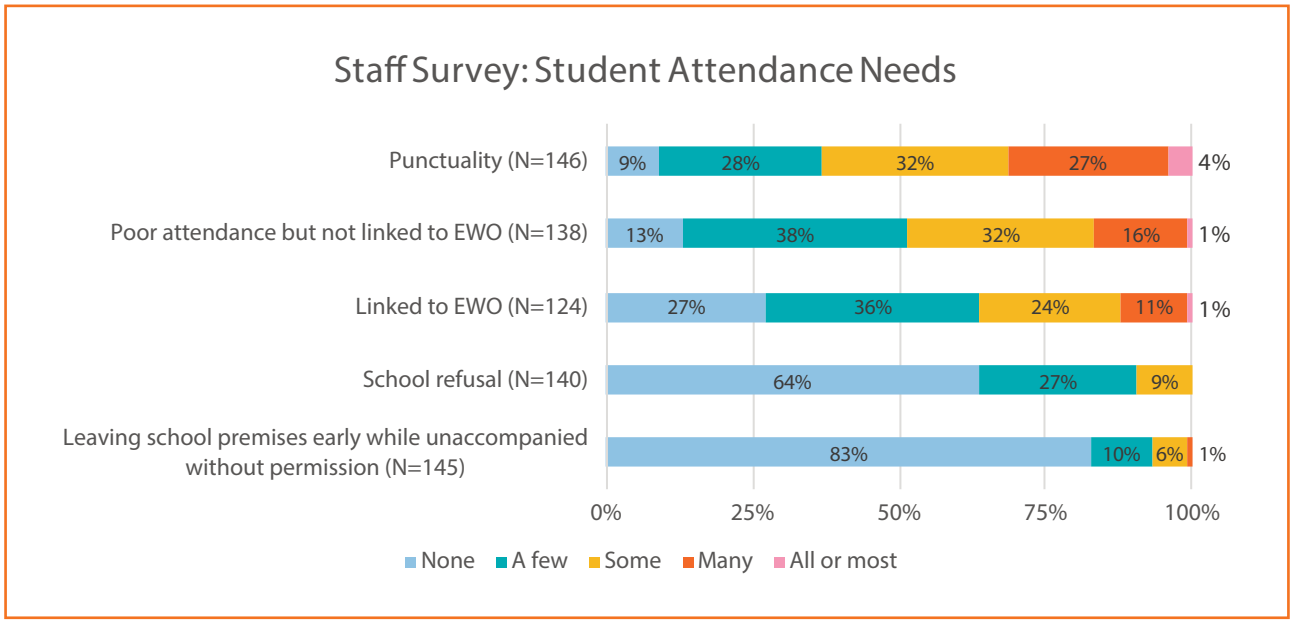
In terms of attendance, 91% of principals indicated that 'Many/Some' students have poor attendance but are not linked to the EWO followed by needs in relation to punctuality with (82% Many/Some). The third highest school attendance need arises from a combination of 'Some/A few' and comprises students linked to the EWO (100% Some/A few) and with school refusal (73% Some/A few) fourth highest. 45% of principals indicated that no students left school premises early unaccompanied without permission and 27% shared that no students had school refusal needs. These findings indicate that, according to principals, the most prevalent need students have in relation to attendance is poor attendance that is not linked to the EWO.

Chart 12 Principal ranking of school attendance needs



Staff responses were more varied across response items. The vast majority (83%) indicated that no students left school premises early unaccompanied without permission, almost double the response of principals (45%). The most prevalent attendance need staff identified was in relation to 1. Punctuality (31% Many/ All or Most), followed by 2. Poor attendance but not linked to EWO (17% Many/All or Most) and Linked to EWO (13% Many/All or Most). In comparison to 27% of principals, almost two thirds of staff (64%) indicated that no student had school refusal needs.

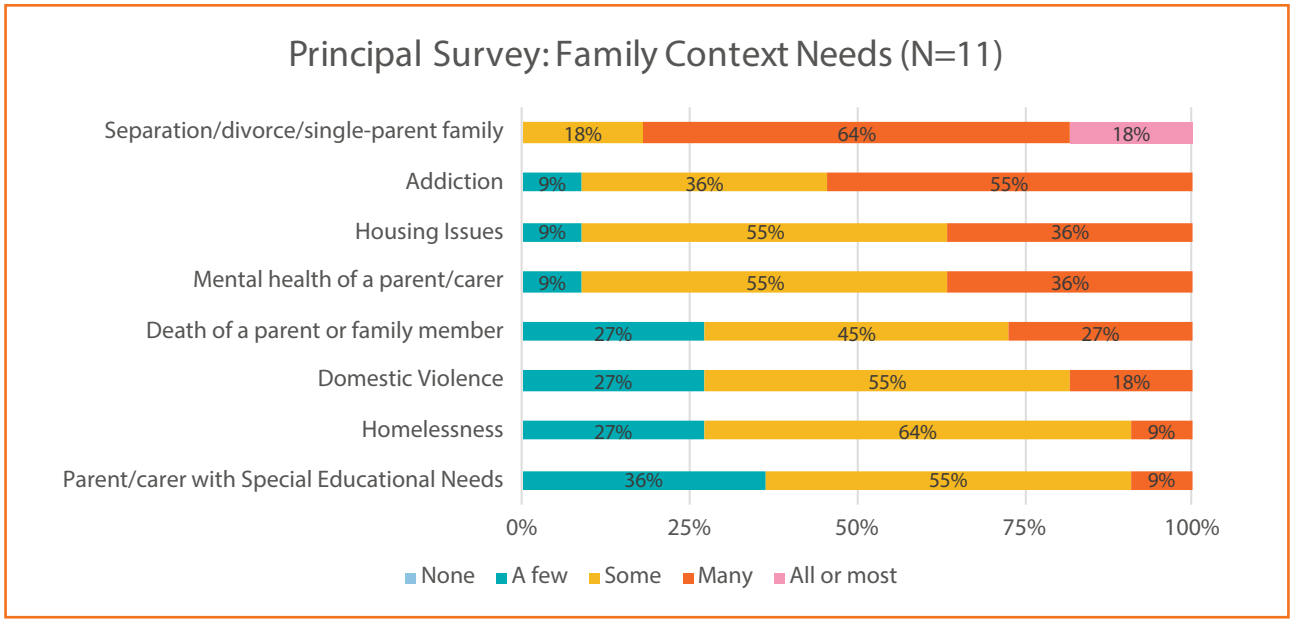
Chart 13 School staff ranking of school attendance needs



Family Context needs

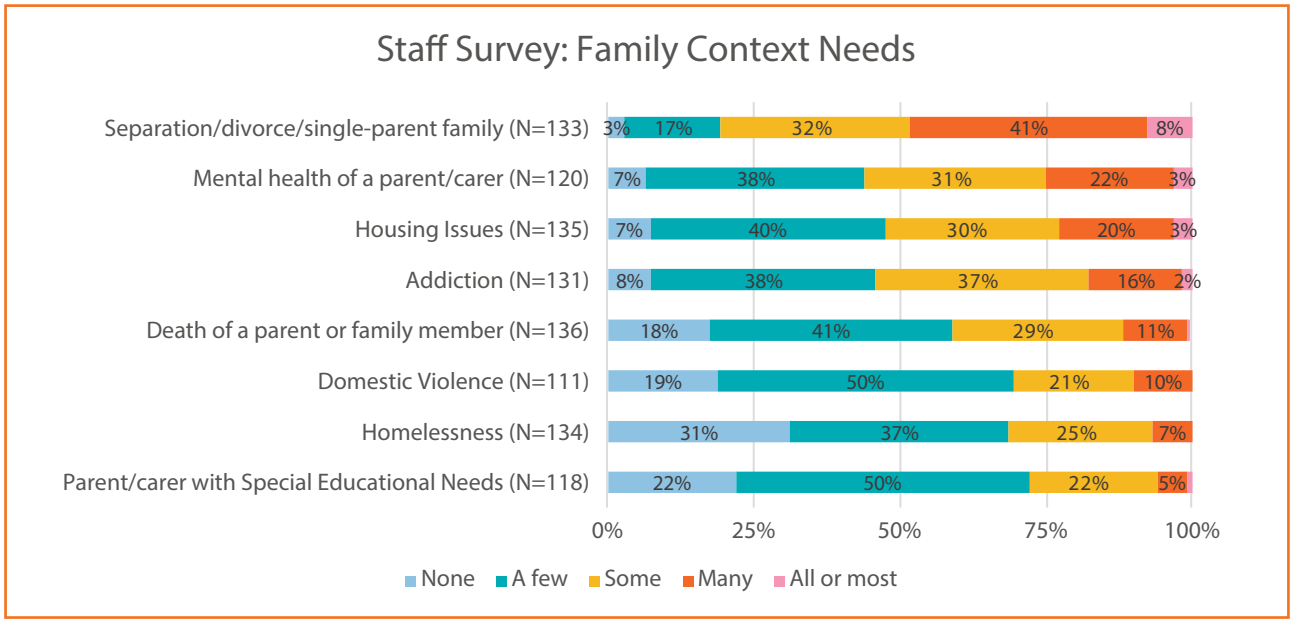
As detailed in **Chart 14**, the most prevalent family context needs reported by principals was separation/divorce/single-parent family (82% Many/All or Most). This was followed by 2. Addiction (91% Some/Many). Housing issues and Mental Health of a parent/carer were placed joint third (91% Some/Many), followed by Domestic Violence and Homelessness at joint fourth (73% Some/Many). This was followed by 5. Death of a Parent/Carer (72% Some/Many), and finally, 6. Parent/Carer with Special Educational Needs. Of note is that no principal responded 'None' to any of these family context needs.

Chart 14 Principal ranking of family context needs



Staff also identified Separation/divorce/single-parent family (49% Many/All or Most) as the most prevalent family context need as outlined in **Chart 15**, followed by 2. Mental Health of a Parent/Carer (25% Many/All or Most), 3. Housing issues (23% Many/All or Most) and 4. Addiction (17% Many/All or Most). Death of a parent or family member came fifth (40% Some/Many), followed by 6. Homelessness (32% Some/Many), 7. Domestic Violence (31% Some/Many), and finally, 8. Parent/Carer with Special Educational Needs (27% Some/Many). As evident in **Chart 15**, staff displayed greater variation in responses than principals and for each category of family need. They were also more likely to indicate that none of their students had needs ranging from 3% in Separation/divorce/single-parent family to 31% indicating that no student had needs related to Homelessness. It is possible that some teachers may be less likely to be aware of family context needs given the key role that HSCLs in DEIS schools play interacting with and supporting parents/families. As highlighted above, principals may be privy to more sensitive information about family context than teachers.

Chart 15 School staff ranking of family context needs



Other needs

Chart 16 reveals that Community Context needs were the most prevalent need identified by principals in the 'other' needs category (81% Many/All or Most), followed by 2. Nutrition (63% Many/All or Most), 3. General Health (45% Many/All or Most), 4. Clothing (18% Many/All or Most), 5. Student with assigned social worker (36% Some/Many), 6. Living in Care (82% A few/Some) and finally, 7. Substance Abuse (by student) (64% A few/Some).

Chart 16 Principal ranking of other needs

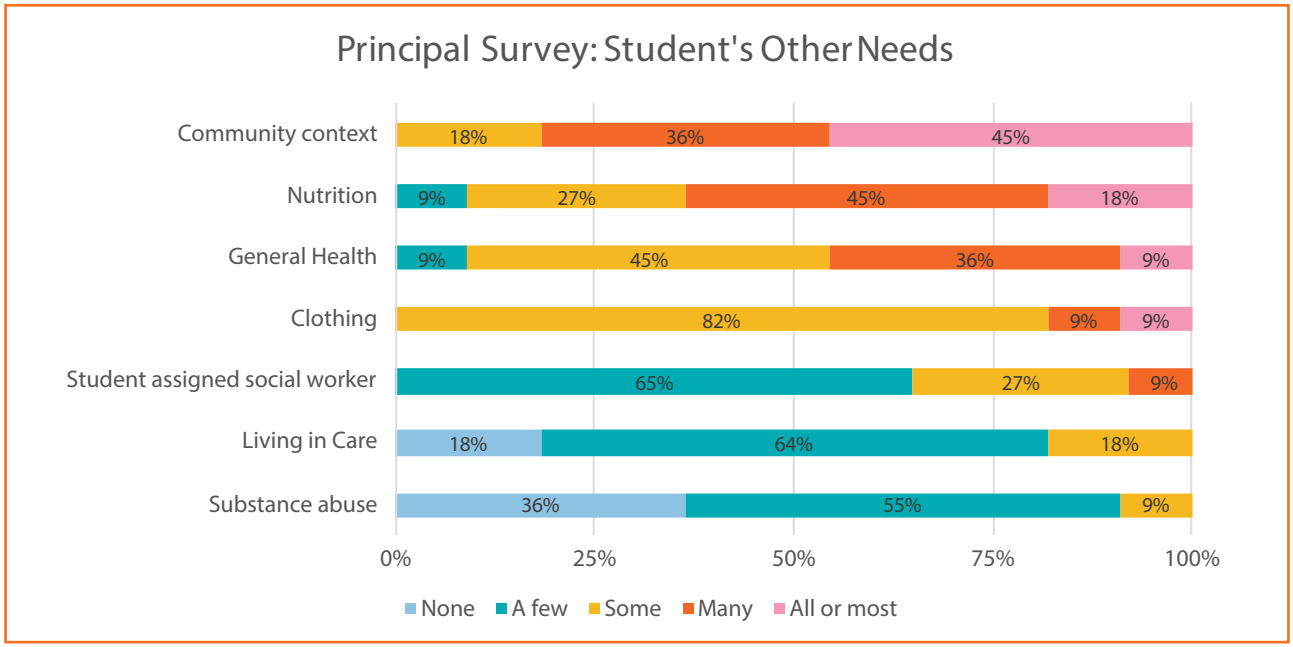
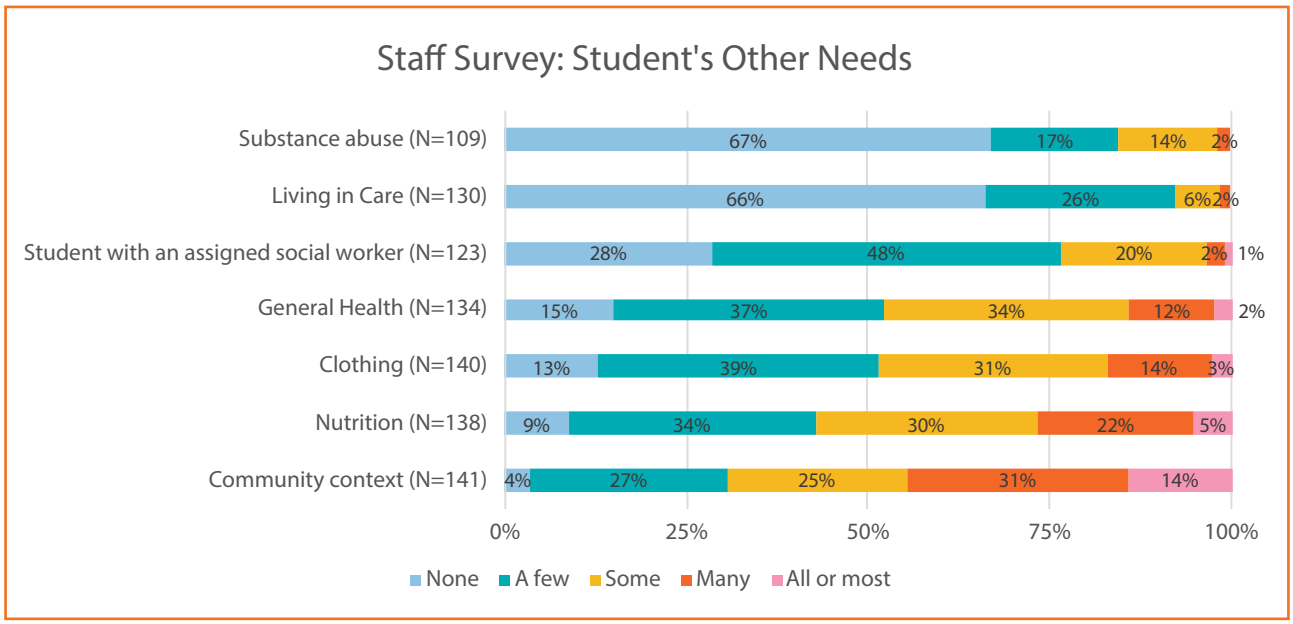


Chart 17 shows that school staff also identified Community Context (45% Many/All or Most) as the most prevalent 'other' need. This was followed by 2. Nutrition (28% Many/All or Most), 3. Clothing (17% May/All or Most), 4. General Health (14% Many/All or Most), 5. Student with assigned social worker (3% Many/All or Most) 6. Living in care (8% Many/Some) and finally, 7. Substance Abuse (14% Some/A few).

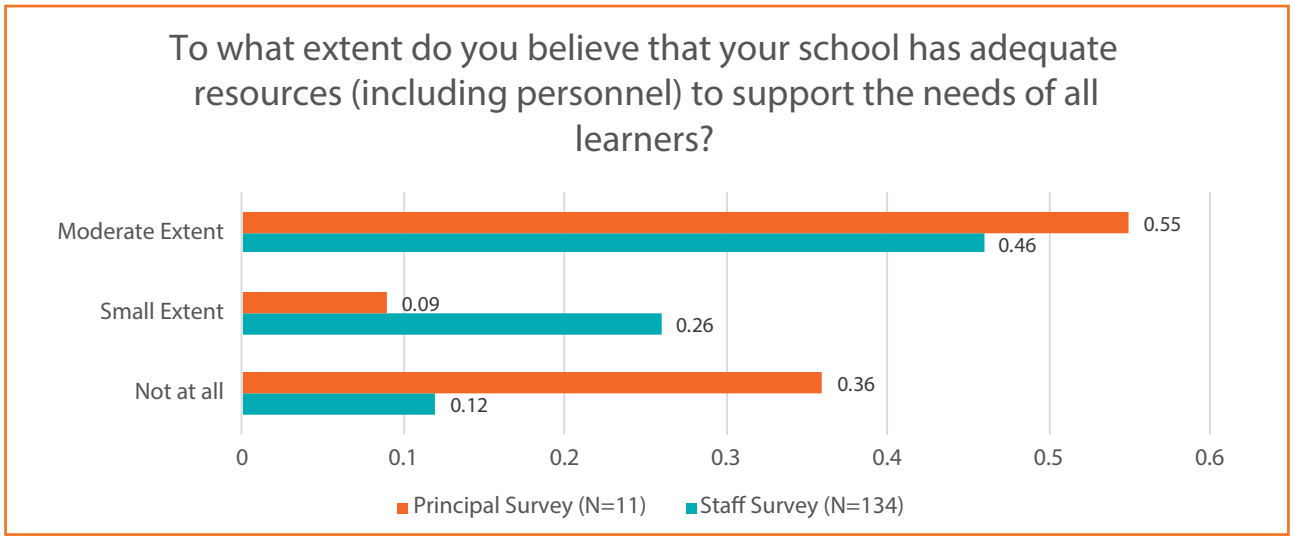
Chart 17 School staff ranking of other needs



Adequacy of resources to meet needs

Principal (N=11) and staff (N=134) survey respondents were asked to what extent they believe the school had adequate resources (including personnel) to meet the needs of all learners. **Chart 18** reveals that over a third of principals (36%) believe they do not have adequate resources to any extent in comparison to 12% of staff surveyed. The majority of principals (55%) and staff (45%) believe they have adequate resources to a 'moderate extent'. Just over a quarter (26%) of staff felt they had adequate resources to 'some extent' compared to 9% of principals.

Chart 18 Extent to which the school has adequate resources to meet students' needs



Students who need to avail of services

Chart 19 below shows that the top four most prevalent services that principals and staff believe students need are:

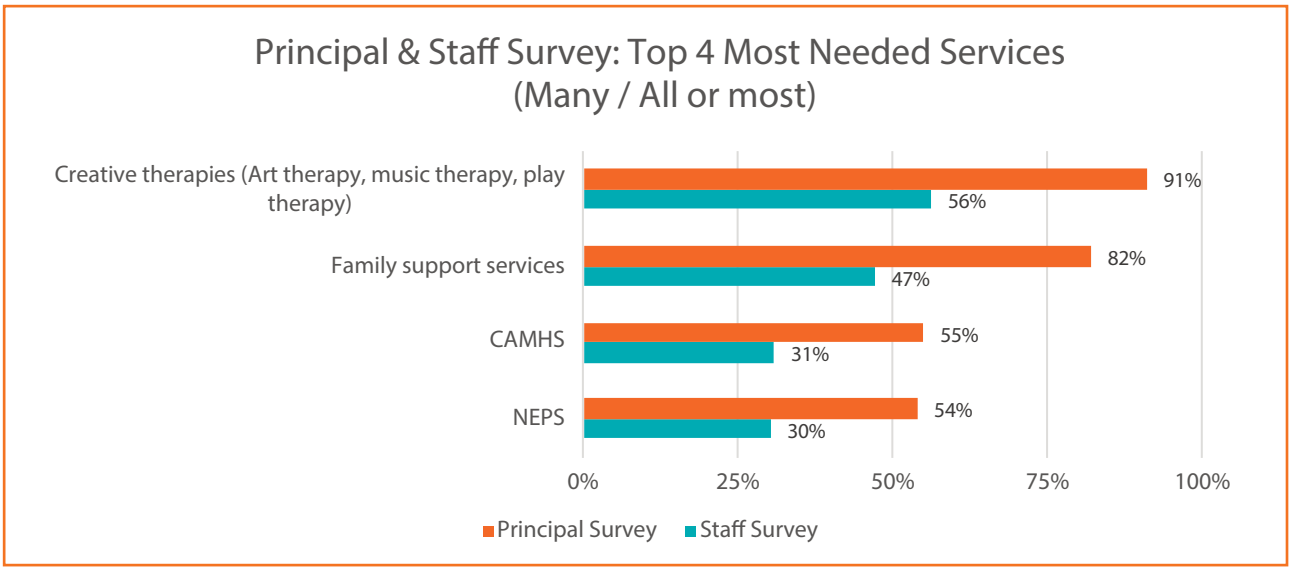
1 Creative Therapies – 91% of principals and 56% of staff indicated that 'Many/All or Most' students need to avail of these services.

2 Family Services – 82% of principals and 47% of staff indicated that 'Many/All or Most' students need to avail of these services.

3 CAMHS – Over half (55%) of principals and 31% of staff indicated that 'Many/All or Most' students need to avail of these services.

4 NEPS – Over half (54%) of principals and 30% of staff indicated that 'Many/All or Most' students need to avail of these services.

Chart 19 Services most required to meet students' needs

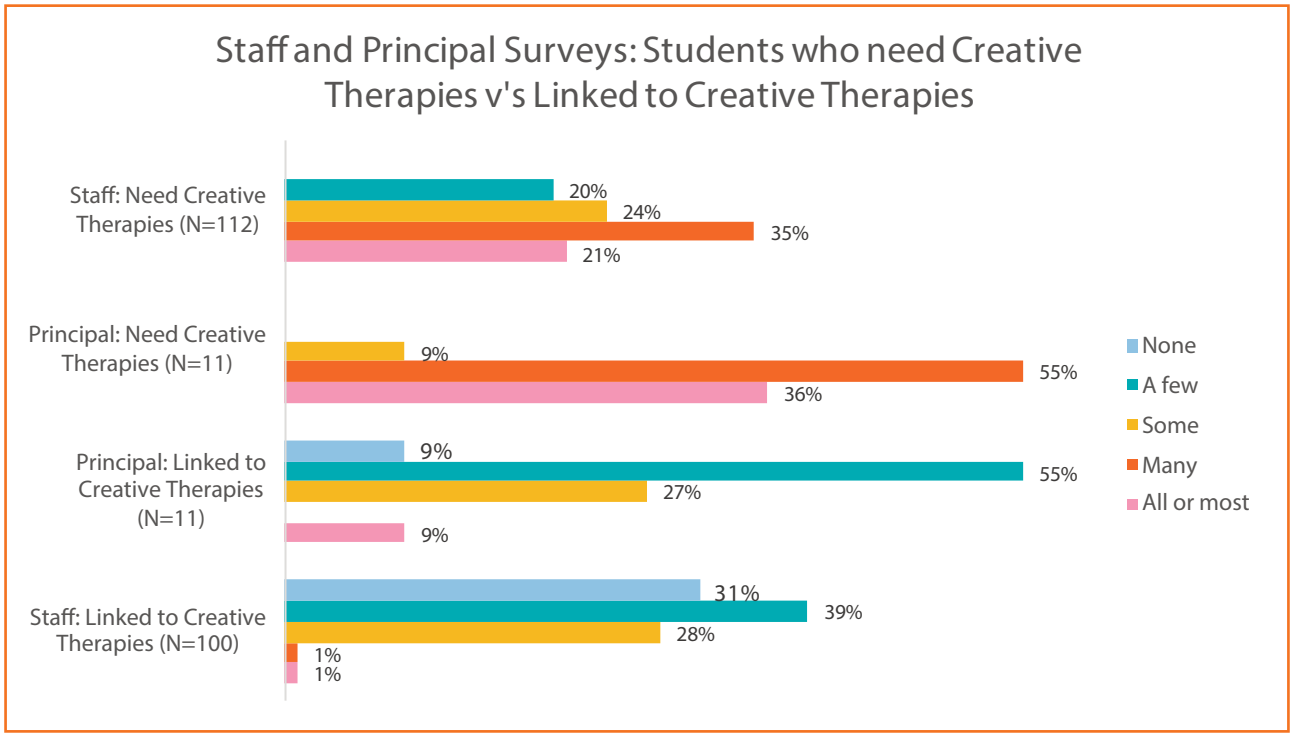


Mental Health Services

Creative Therapies were the service that principals and staff indicated students were most in need of and **Chart 20** shows however, that to the best of their knowledge, the majority of principals (55%) believe that only 'A few' are linked to these services, followed by 'Some' (27%) and 'None' (9%). Staff responses were more evenly distributed, with 22% believing that 'All or Most' students need to avail of these services, 35% of the view that 'Many' do, 24% indicating 'Some' and 20% indicating 'A few'.

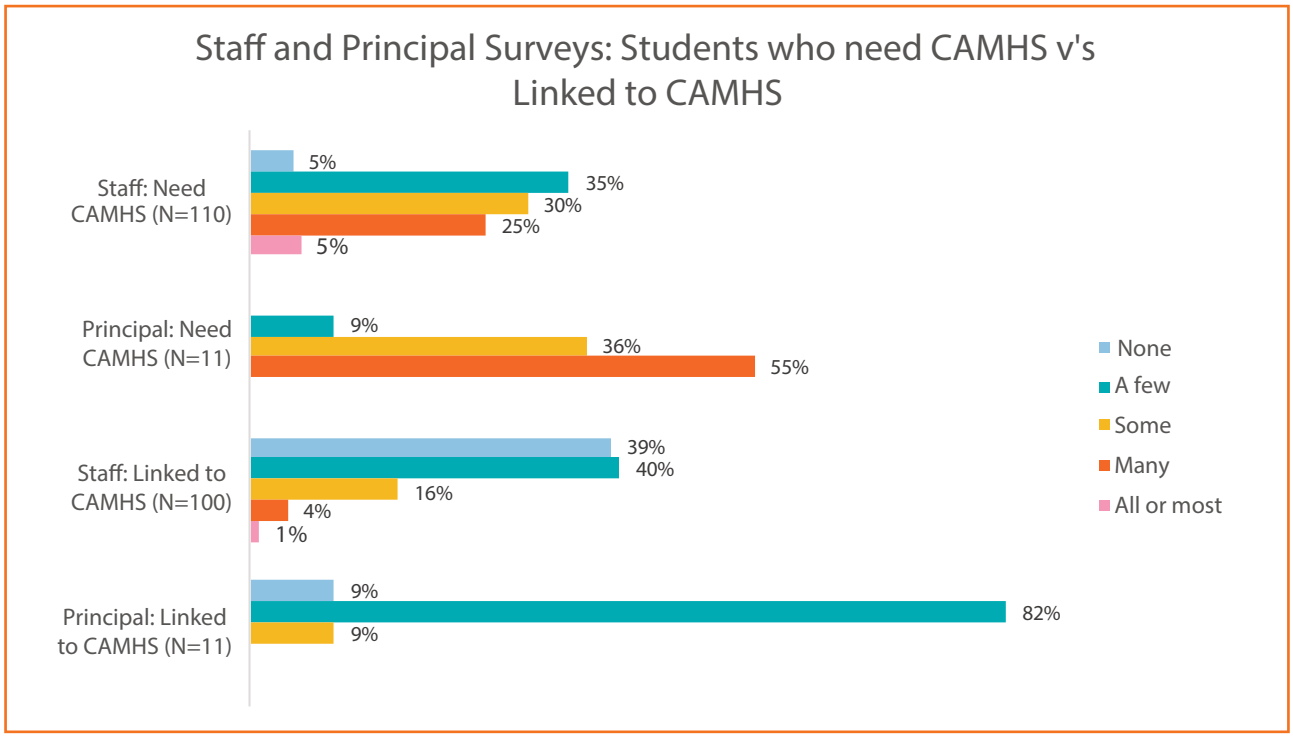
Chart 20 also shows the disparity between the number of students that principals and staff believe need these services in comparison to those they believe to be linked to them, with only 1% of staff and 9% of principals indicating that 'All or Most' and only 1 % of staff indicating that 'Many' are actually linked to these services. Of particular note regarding Creative Therapies is that no principal or staff respondent indicated that 'None' of their students need Creative Therapies. However, we can see that 31% of staff and 9% of principals belive that 'None' of their students are linked to these services.

Chart 20 Students who need versus linked to Creative Therapies



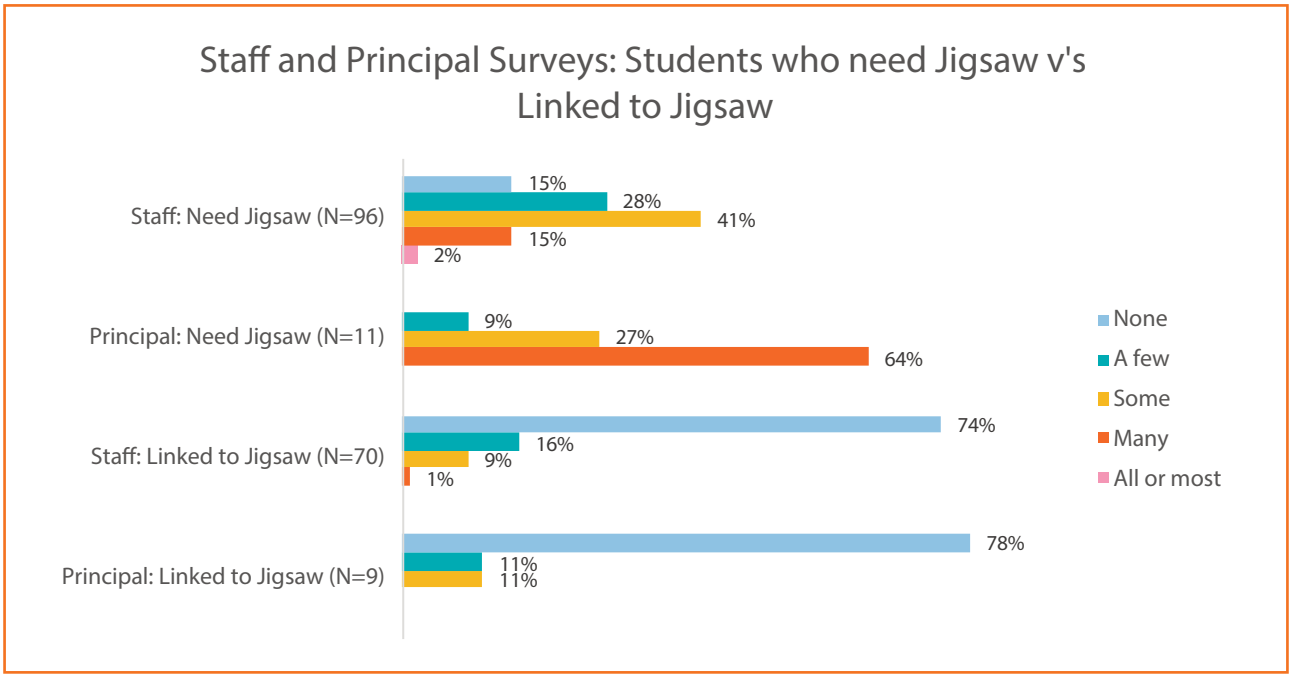
From **Chart 21**, we can see that over half of principal survey respondents are of the view that 'Many' students need to be linked to CAMHS (55%) in comparison to a quarter (25%) of staff respondents. However, the majority of principals (81%) and staff (40%) believe that only a few are linked to the service.

Chart 21 Students who need versus linked to CAMHS



Nearly two thirds of principals (64%) indicated that 'Many' of their students need to avail of Jigsaw in comparison to 15% of staff as detailed in **Chart 22**. In contrast, the vast majority of prinicipals (78%) and staff (74%) were of the view that only 'A few' were linked to the service.

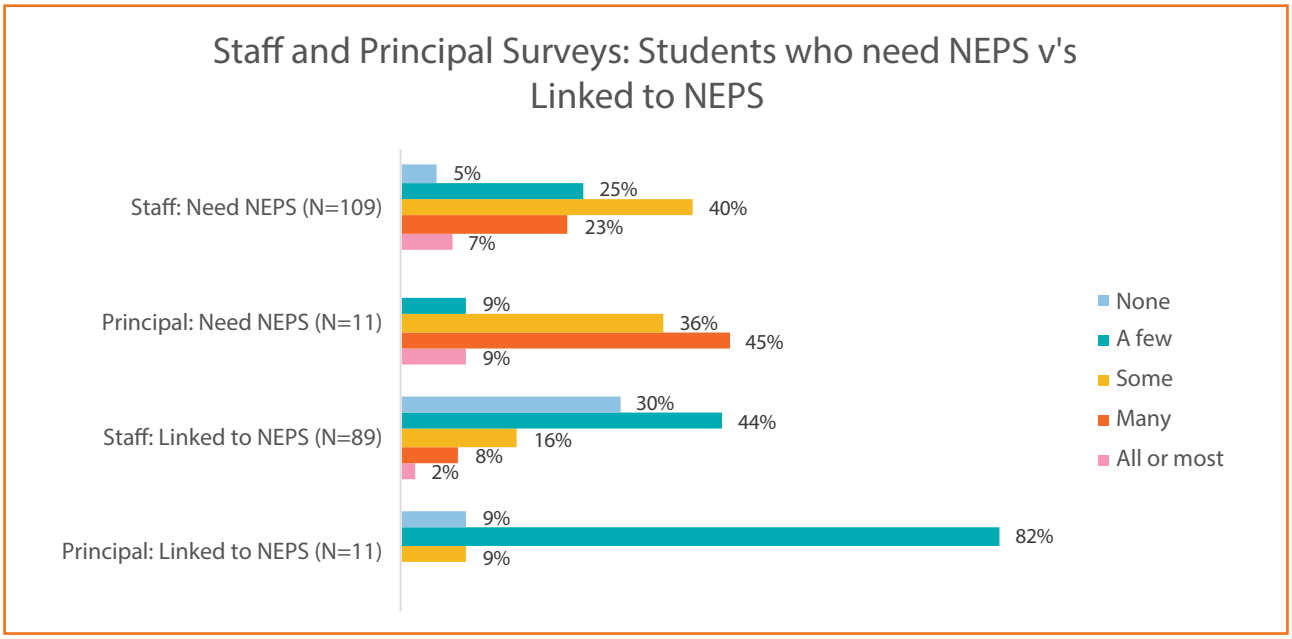
Chart 22 Students need versus linked to Jigsaw



Education Services

Most principal survey respondents (45%) indicated that 'Many' of their students need to avail of NEPS as evident in **Chart 23**, followed by 36% selecting 'Some' and 9% 'All or Most'. However, the vast majority (82%) relayed that only 'A few' were linked to the service. The majority of staff were of the view that 'Some' students need NEPS, followed by 'A few' (25%), 'Many' (23%), 'All or Most' (7%). As with principals, the majority also indicated that only 'A few' (44%) were linked, followed by 'None' (30%). A tiny percentage (2%) indicated that 'All or Most' students were linked to NEPS.

Chart 23 Students who need versus linked to NEPS

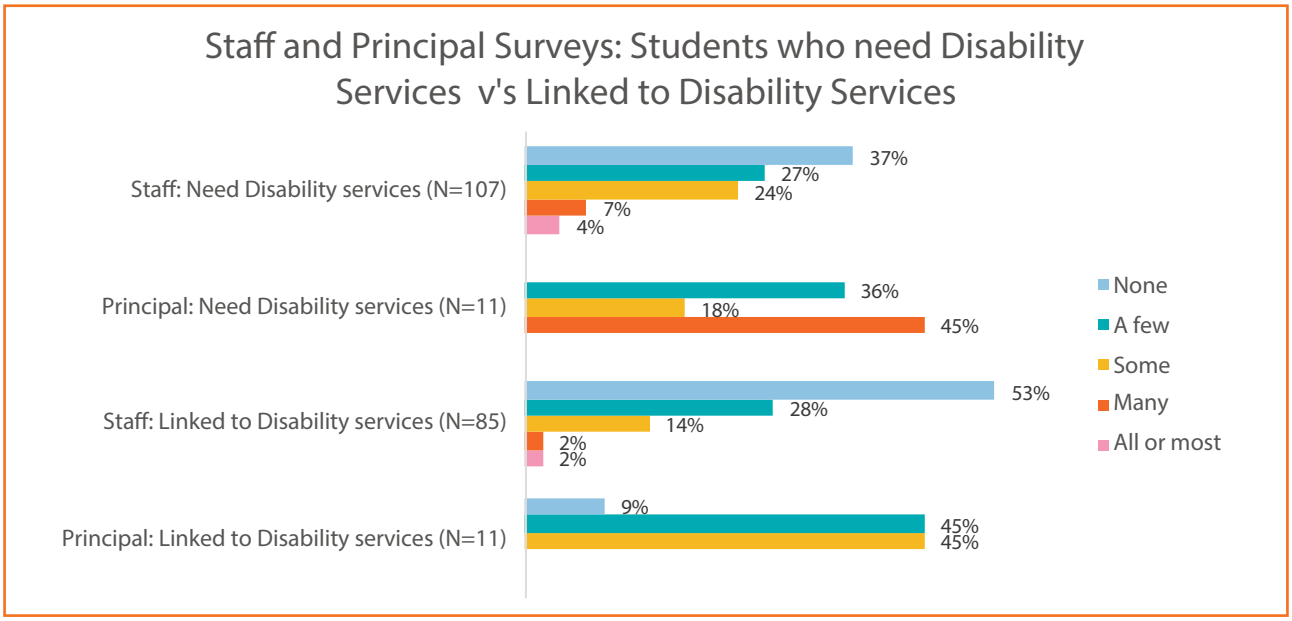


Other services

Disability Services

Chart 24 shows that 45% of principal survey respondents indicated that 'Many' students need to avail of disability services, followed by 'A few' 36% and 'Some' 18%. However, only 'A few' (45%) and 'Some' (45%) were believed to be linked to such services. Staff were far less likely to be of the view that students needed disability services, with the majority (37%) indicating that 'None' needed such services. However, 27% indicated that 'A few' need disability services, followed by 'Some' (24%). Over half 53% indicated that students were not linked to disability services followed by 28% indicating 'A few' were.

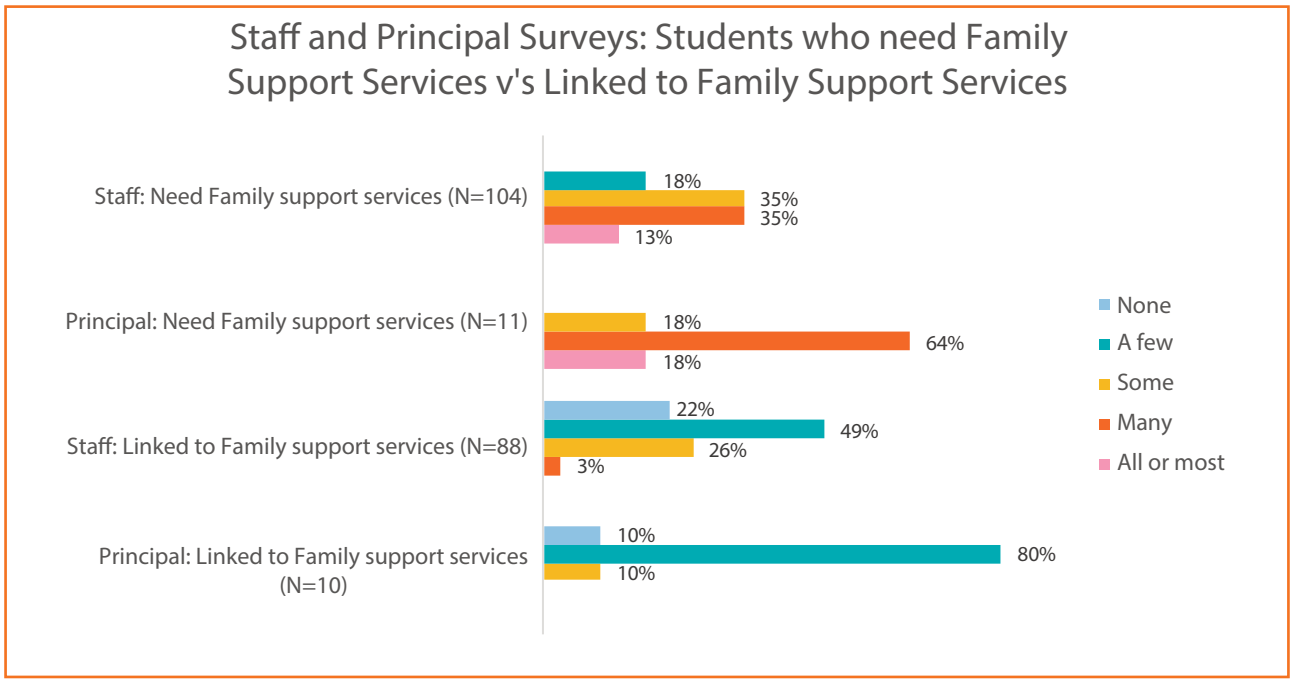
Chart 24 Students need versus linked to disability services



Family Support

The majority (64%) of principal survey respondents indicated that 'Many' students need to avail of Family Support services, followed evenly by 'All or Most' and 'Some' (18%). In contrast, the vast majority (80%) indicated that only 'A few' students are actually linked to these services. **Chart 25** below shows that 12% of staff believe that 'All of Most' students need to avail of Family Support services. An equal number of staff (35%) indicated that 'Many' and 'Some' need to avail of Family Support, followed by 'A few' (18%). Staff responses indicate that 'A few' (49%) are linked to such services, followed by 'Many' (18%). However, over a fifth (22%) indicated that 'None' were linked to these services.

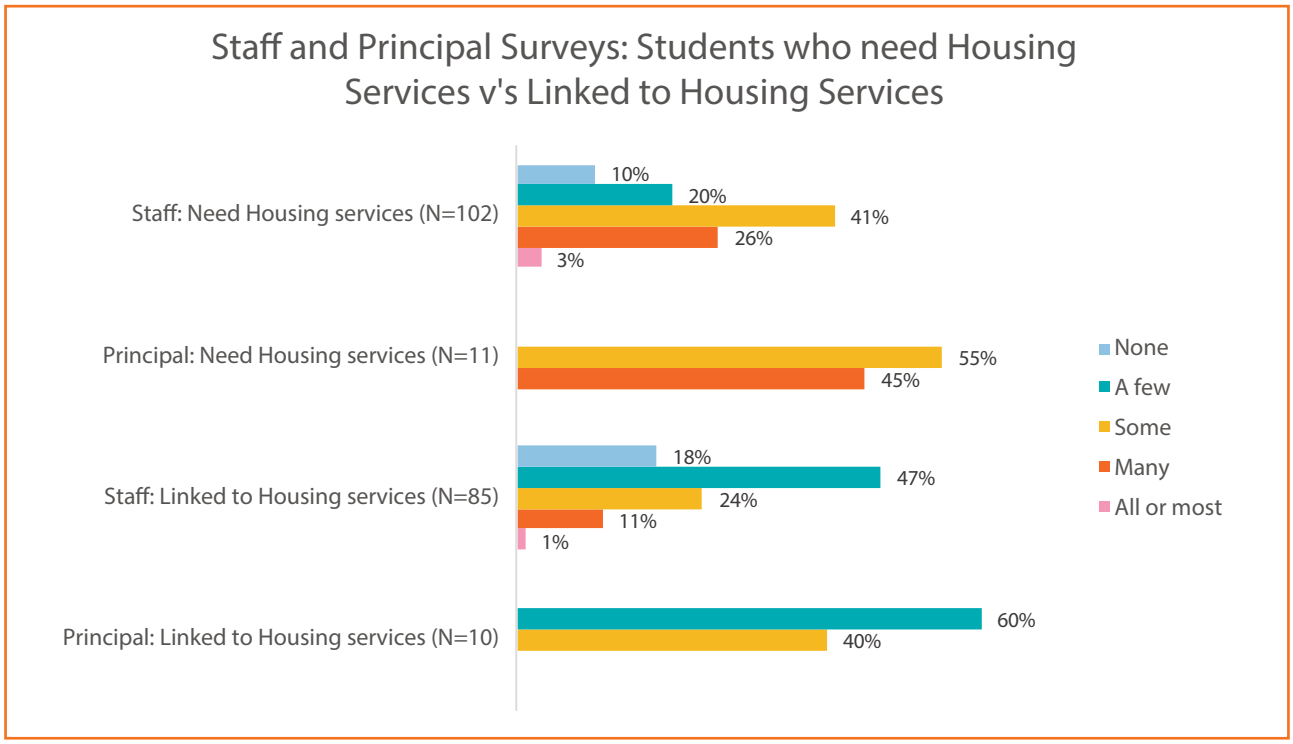
Chart 25 Students who need versus linked to family support services



Housing

Over half of principal respondents indicated that 'Some' students need housing services, followed by 'Many' (45%). However, the majority (60%) indicated that only 'A few' were linked to these services, followed by 'Some' (40%). Over a quarter (26%) of staff indicated that 'Many' students were in need of housing services, with 41% indicating 'Some' and a fifth selecting 'A few' (20%). In contrast, the majority were of the view that 'A few' (47%) were linked to services in this area, followed by 'Some' (24%).

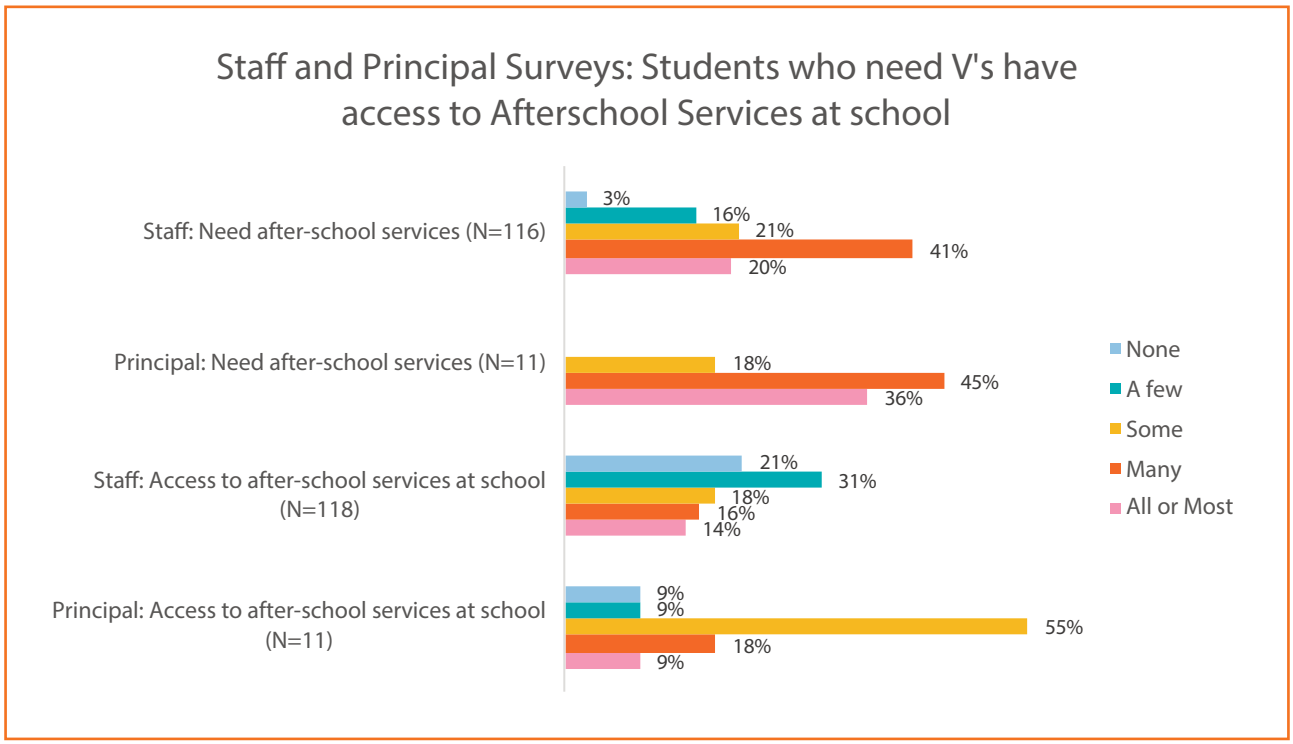
Chart 26 Students who need versus linked to housing services



Afterschool Services

Chart 27 below shows that all principals and the vast majority of staff (97%) believe that all children need afterschool services onsite at school. However, approximately a fifth (21%) of staff indicated that none of their students have access to these services at school, followed by 'A few' at 31%, 'Some' at 18%, 'Many' at 16% and 'All or Most' at 14%. Over half of principals (55%) indicated that 'Some' have access to afterschool services at school, followed by 'Many' 18% and 'All or Most', 'A Few' and 'None' at 9%.

Chart 27 Students who need versus linked to afterschool services at school



Role of the school in meeting children's non-academic needs

Feedback from across parents, staff focus groups and principal interviews clearly shows that the schools involved in the research play a crucial role in addressing students' non-academic needs in addition to nurturing their overall well-being and development. Beyond academic instruction schools provide emotional support, help students to develop social skills, manage stress and trauma and build resilience to thrive in their community. Indeed, one parent stated that non-academic support *'is more important for my child at the moment'* (Parent 12).

Parents, principals and staff focus group participants stressed that children cannot learn until their emotional needs are met, and they are regulated, as evident in the following quotes:

> *'At the end of the day a child spends the majority of the day here in school. If they're not mentally capable they won't be able to focus and learn and take in what they're supposed to be learning'* (Parent 5).

> *'Priority needs, I think social and emotional well-being really and to enable them to have the regulation to approach their work. So again, the priority needs, we want to be able to provide our children with the same curriculum as any other school and give them the same chances. But that involves making sure that they are not hungry when they come to school, that they're nourished, you know, and that their physical well-being and their emotional well-being is at a place, you know, there's anxieties there from the things that are maybe are happening at home'* (Principal 6).

> *'Speaker 1: For a lot of the children that would be on the upper part of the support continuum, the main target for them is their emotional wellbeing or regulation, because we can't attend to learning unless that's, unless they're regulated and emotionally ready for school. We would have a cohort of children that come in, they're not ready for learning because of different things that might be going on at home or in the community and you can't drive on with academics before meeting those needs'* (Teacher School 13).

The trauma that some children experience in their day to day lives, arising from a variety of sources e.g., bereavement and separation, domestic violence, community violence, racism, drug abuse and addiction, incarceration and housing issues, was highlighted by principals and school staff. The caring and nurturing role that staff play in children's lives was emphasised with some observing that for some children, school is *'the best part of their day'* and a place where they are cared for, safe, warm and fed.

> *'Speaker 2: We find that some of our children, school is the best part of their day. It's the kindest words. The warmest. They get fed. They come in to warm building and they are minded'* (Teacher School 9).

> *'I think they need a huge amount of care. They need a lot of personal, individualized attention. I think many of them crave it. Some of them look for it in the wrong ways, but I definitely feel that there is a strong need for a care, support, attention'* (Principal 4).

All school staff focus groups and principals detailed a wide variety of non-academic supports they provide for children and parents. For children, these included: onsite therapeutic support e.g., play or music therapy, delivered through Blue Box[18] or other private fundraising by schools, speech and language, physio and occupational therapy provided onsite if the school is part of the HAPPEE Project or in some instances, provided by therapists from the local primary care centre. Family learning activities e.g., family baking, family literacy, family woodwork, that provide opportunities for parent and child interaction to support connections, learning and developing life skills were also offered.

The majority of schools incorporate afterschool activities, summer camps and other opportunities in a variety of areas to meet children's interests and needs. School staff perceived these activities as important as children may not normally get the opportunity to participate in such activities outside of school. Some schools also refer children to other agencies e.g., Limerick Youth Service, for support after school. Most child focus group participants indicated that they availed of afterschool activities in school and relayed that they were fun, supported healthy activity, helped to reduce screentime and to avoid *'bold people'* (Child Focus Group 2 SP2[19]) after school. Very few had access to afterschool clubs in the community. Staff in schools located in the city centre highlighted the lack of clubs and sporting facilities nearby and the role that they play in trying to fill the gap in extracurricular activities and opportunities which might be delivered by sports organisations and other community groups. Schools offer activities to develop social skills e.g., Friendship Week was mentioned by one, as well as programmes and activities in a variety of areas such as wellbeing, internet safety, healthy eating etc. to their curriculum.

School staff highlighted that they support nutritional needs via breakfast clubs, school lunches, afterschool meals and clothing and hygiene needs where necessary. The schools interviewed also described how their schools integrate movement breaks to develop motor skills and to respond to sensory needs. One staff member observed how school being a source of '*structure*', '*routine*', *'support'*, *'care'* and '*safety'* for many children from 8am in the morning until 4.30/5pm and staff are trusted adults in children's lives.

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[18] Blue Box Creative Learning Centre works with schools in Limerick City and environs to provide psychotherapy services to vulnerable children, young people and their families. For further information, see https://bluebox.ie/

[19] SP=Speaker

Findings from the Photovoice study

Three students participated in the photovoice study (see Section Four - **Photovoice** for details) where they explored what they like or would like to change about their school through photographs they took themselves. Findings highlight the importance of creative, relaxing, and supportive environments to facilitate students with multidisciplinary support needs to engage in learning. They also illuminate the importance for students of the non-academic aspects of school life, underscoring the significance of Oscailt schools' efforts to support non-academic needs of students as outlined in the previous section. Students reported enjoying physical activities but identified a need for more variety and better facilities. Mental wellbeing is supported through sensory and mindfulness spaces, while social connections and recognition for achievements contribute significantly to students' happiness. There is a clear desire for more autonomy, free time, and a later start to the school day. Multisensory experiences and food-related activities are also significant, reflecting the diverse needs and preferences of students.

The importance of creative and relaxing spaces

Creative spaces within the schools, such as the woodwork room, stage, and art areas, were highly valued by students, as they foster an environment conducive to creative expression. Additionally, relaxing areas like the mindfulness room and vibrant murals play a significant role in cultivating a positive atmosphere. Students particularly appreciated activities that enhance their self-esteem, including those related to art and singing. Engaging in hands-on creative endeavours, such as working with LEGO or playing a music app, were seen as essential for their development. Furthermore, spaces designed for comfort and relaxation, including the sensory room and picnic bench on the yard, contribute to an overall sense of well-being, making these environments indispensable to the students' educational experience.

> *'I love acting. This picture* [of a stage] *tells us that this school can be creative'* (Photovoice Child 1).

> *'We took a photo of that wall because it's colourful and relaxing for children when they walk in. It says that you're unique and loved and safe and that's true'* (Photovoice Child 1).

> *'I like crafts and paintings'* (Photovoice Child 2)

> *'That's our LEGO spot. I like LEGO. I built this'* (Photovoice Child 3).

Physical activities and facilities

Physical Education was enjoyed by the students and viewed as enhancing their learning and development. The enjoyment of yard time and the appreciation of outdoor play areas further highlighted the importance of physical activity to the children. These outdoor environments not only provide students with the opportunity for relaxation and social interaction but also contribute to their overall well-being, reinforcing the vital role that physical activity plays in fostering a positive and enriching learning atmosphere.

> *'We do PE here – it's really fun. When you do sports, and you come back to class you're ready to learn more'* (Photovoice Child 1).

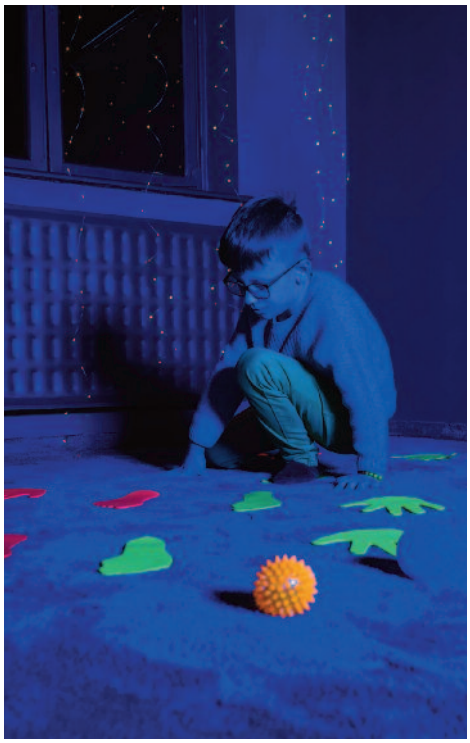
> *'I love yard time. We all have games there. The student council got skipping ropes for the school recently'* (Photovoice Child 1).

> *'I like to relax on the yard'* (Photovoice Child 3).

Mental wellbeing and supportive environment

The availability of school facilities, such as a mindfulness room and music room, play a crucial role in promoting students' mental wellbeing. Additionally, the presence of a sensory pod and a therapy dog reflects the schools' commitment to fostering a supportive and inclusive environment. Beyond these resources, the quality of students' social interactions significantly influences their overall experience, as friendships and engagement with supportive adults contribute to a sense of belonging and emotional security. The students placed great value on receiving awards and recognition for their achievements, which serves as a source of motivation and affirmation. Collectively, these factors contribute to a positive and enriching school experience.

> *'We have a sensory pod photo because everybody is included here. The school supports everyone'* (Photovoice Child 1).
>
> *'This is* [secretary's office] *because I love her, and she likes me'* (Photovoice Child 2).
>
> *'This is the multisensory room where I go. That's a Toni box – I love Elsa. She sings songs and tells stories'* (Photovoice Child 2).



Social Connections

Friendships, supportive staff, and positive interactions play a crucial role in enhancing students' happiness and emotional well-being. The significance of supportive relationships was highlighted by the mention of the secretary's office as a positive space, highlighting the impact of staff members who foster a welcoming and supportive environment. Additionally, students highly valued social interactions, as they enjoy engaging in conversations and spending time with friends, reinforcing the importance of peer relationships in shaping their overall school experience.

> *'I love playing with* [my SNA] *in the sensory room'* (Photovoice Child 2).

> *'I took this because it's* [secretary's] *office'* (Photovoice Child 2).

> *'That's a picnic bench. I sit there and talk to my best friend'* (Photovoice Child 3).

Multisensory Activities

The availability of spaces, such as the mindfulness room and play therapy areas, was highly valued for their calming and therapeutic benefits. The sensory room and related activities play a crucial role in supporting students' mental health by providing a safe and soothing environment. Additionally, the emphasis on tactile experiences, such as touching objects and taking a picture of a hand, underscores the significance of sensory engagement in fostering emotional regulation and overall well-being.

> *'I love mindfulness. Then when you come back to class, you're very zen'* (Photovoice Child 1).

> *'I like hiding under the table'* (Photovoice Child 2).

> *'I took a picture of my hand because I like touching things'* (Photovoice Child 2).

> *'I must say I like touching the sand'* (Photovoice Child 3).

> *'It's a nice classroom. It has a sensory room and a soft play room'* (Photovoice Child 3).

Environmental Initiatives and Student Participation

The presence of green spaces and gardening activities highlights the significance of environmental initiatives in fostering a connection with nature and promoting sustainability. The emphasis on green initiatives and environmental projects further suggests the development of a strong eco-conscious culture among students, encouraging responsibility and awareness of environmental issues. Additionally, the active involvement of the student council in enhancing school life, such as through the implementation of buddy benches, demonstrates the importance of student participation.

> *'We have a lot of plants in here and flowers and stuff. We love plants here. We do a lot of things for the environment here. We're very green'* (Photovoice Child 1).

> *'We have a fish tank and it's really relaxing and zen. It tells us we're a calm school'* (Photovoice Child 1).

> *'The student council made the buddy bench. It tells us that we're a nice school with good ideas'* (Photovoice Child 1).

Preferences for school improvements

Students expressed a desire for greater autonomy and flexibility during school hours, emphasising the importance of having more choices and free time throughout the day. There was interest in starting school later to allow for increased rest, which could enhance students' energy levels and overall well-being. While physical education was generally well-received, students expressed a preference for a greater variety of sports, with less emphasis on soccer. Outdoor play areas were also highly valued, but there was a desire for improvements in playground surfaces and a broader range of activities on the yard during break times. Furthermore, students indicated a preference for a reduced academic workload, suggesting a need for a more balanced approach to learning that incorporates both structured education and opportunities for relaxation and recreation.

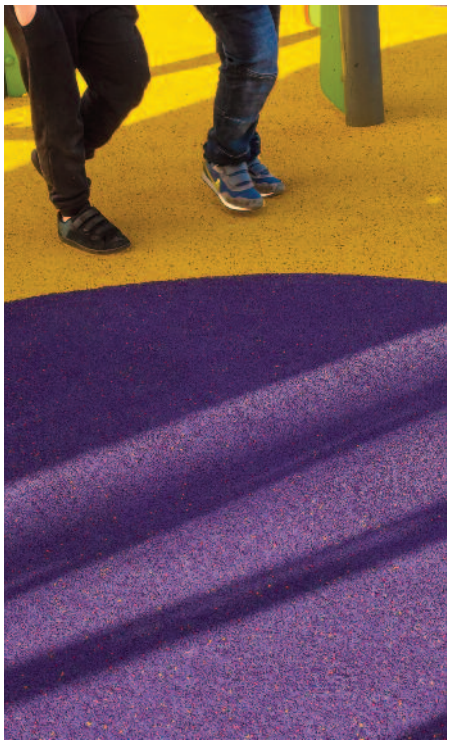
> *'I'd like to change how we do so much soccer in the school. We have a lot of soccer in the school. Whenever we go to PE, we mostly do soccer'* (Photovoice Child 1).

> *'We'd love to see a newer surface on the ground that's more like a playground'* (Photovoice Child 1).

> *'I took a photo of the workbook in the bin because no work'* (Photovoice Child 3).

> *'I'd like more free time in school'* (Photovoice Child 3).

> *'I thought that school should start later'* (Photovoice Child 3).



Positive association with food

Students expressed a positive association with eating and food-related activities, highlighting the role of food and culinary activities in their overall wellbeing and school experience.

> *'That's the kitchen and that is so fun because you get to bake'* (Photovoice Child 1).

> *'I took this picture* [of a pizza] *because I like eating'* (Photovoice Child 3).

> *'This is the kitchen. I took this picture because I like food'* (Photovoice Child 3).

In conclusion, the photovoice findings emphasise the multifaceted nature of students' school experiences, highlighting the importance of creative, physical, multisensory and social environments in fostering well-being and engagement. They also highlight the importance of fostering an inclusive, student-centred approach to education that balances academic learning with opportunities for relationship-building, creativity, relaxation, and personal growth.

Support for parents and the importance of home school communication

Staff focus groups and principal interviews reveal that, in addition to supporting multidisciplinary and non-academic needs of their students, the schools involved also provide a wide variety of supports for parents, many of which were through the HSCL role. Two schools also highlighted that they had a dedicated Family Support Worker in the school.

Support for parents included fostering and improving various skills. Many schools conducted regular parent workshops and classes including craft classes, English language and literacy, computers, study groups, hair, beauty, parenting skills programmes and peer support for parents of children with SEN. In addition, a number of schools provide parent and child family learning support via parent and toddler groups supported by EDNIP, family literacy and numeracy activities, family mastermind, family baking, family art, family woodwork, transition to post-primary to mention a few. Two staff members commented:

> *'Speaker 2: I find that the parents get a lot more involved when the child is involved*
>
> *Speaker 3: The uptake is better, they come in for their child. Even this morning I invited eight parents in for family woodwork and all ages were there'* (Teachers School 2).

In schools where there are parents' councils established, parents support the delivery of activities e.g., Halloween, Christmas or Easter activities. Schools organise parent coffee mornings, information evenings and participation of parents in Intercultural days. HSCLs conduct home visits, facilitate communication with teachers and organise referrals to different support services. They also support parents with filling out referral forms and accompany parents to appointments with their children.

The benefit of schools' efforts to support parents was perceived by one school as being a greater sense of community and sense of belonging amongst parents and families. Another highlighted that there had been a *'paradigm shift'* in recent years regarding support for parents, particularly those in crisis, in order to create meaningful, long-term change in children's lives. Some school staff shared that they provide families with food vouchers and Christmas hampers organised by the SCP, while one school provides psychotherapy and counselling one school directly through their wellness centre.

Parents, staff focus group participants and principals highlighted the importance of good communication and building relationships between home and school for a variety of reasons. Parents emphasised the importance of reciprocal communication that goes *'both ways'*, so that they understand how their child is getting on in school and to inform the school of any concerns that they may have for their child. One parent observed that *'half their day is in school and if you want the best out of your child, both the school and home need to know what's going on with your child'* (Parent 11).

Principals highlighted that parents are the primary educators of their children, and that parental involvement is a cornerstone of the DEIS plan and model. School staff recognised that communication with parents equips them with a greater understanding of the children in their school and to be aware of important things that happening in their lives that might affect their progress or behaviour in school. Good communication was cited by staff as building relationships and trust, facilitating sharing of strategies that work between home and school and creating a more holistic approach to meeting the needs of children.

Both principals and school staff recognised that some parents may have had negative experiences of the education system or may lack trust in school and that it can take time to build up trust with some parents. Having an *'open-door'* policy, developing relationships at the school gate and being a '*familiar face*' (Principal 2) for parents and regular communication were viewed as important in building trust and relationships. One principal described the HSCL role as the '*hidden gem*' (Principal 5) in the DEIS scheme because of the significant role they play in building relationships and trust with parents. At post-primary level, it was felt that building relationships with parents can be more difficult as schools may not be as accessible or '*open-door*' to parents as primary schools due to timetabling and logistics.

Part 2 - Current onsite support and referrals process

This section draws on survey data, and focus groups and interviews with adult research participants to explore what is currently happening in schools that participated in the research regarding onsite delivery of multidisciplinary support, the current referral pathways for children and the levels of variance between school settings in terms of referring students to multidisciplinary professionals both onsite and offsite. The specific areas explored are as follows: 1) current levels of onsite multidisciplinary support; 2) an overview of referral pathways for multidisciplinary support and 3) feedback on referrals both onsite and off-site.

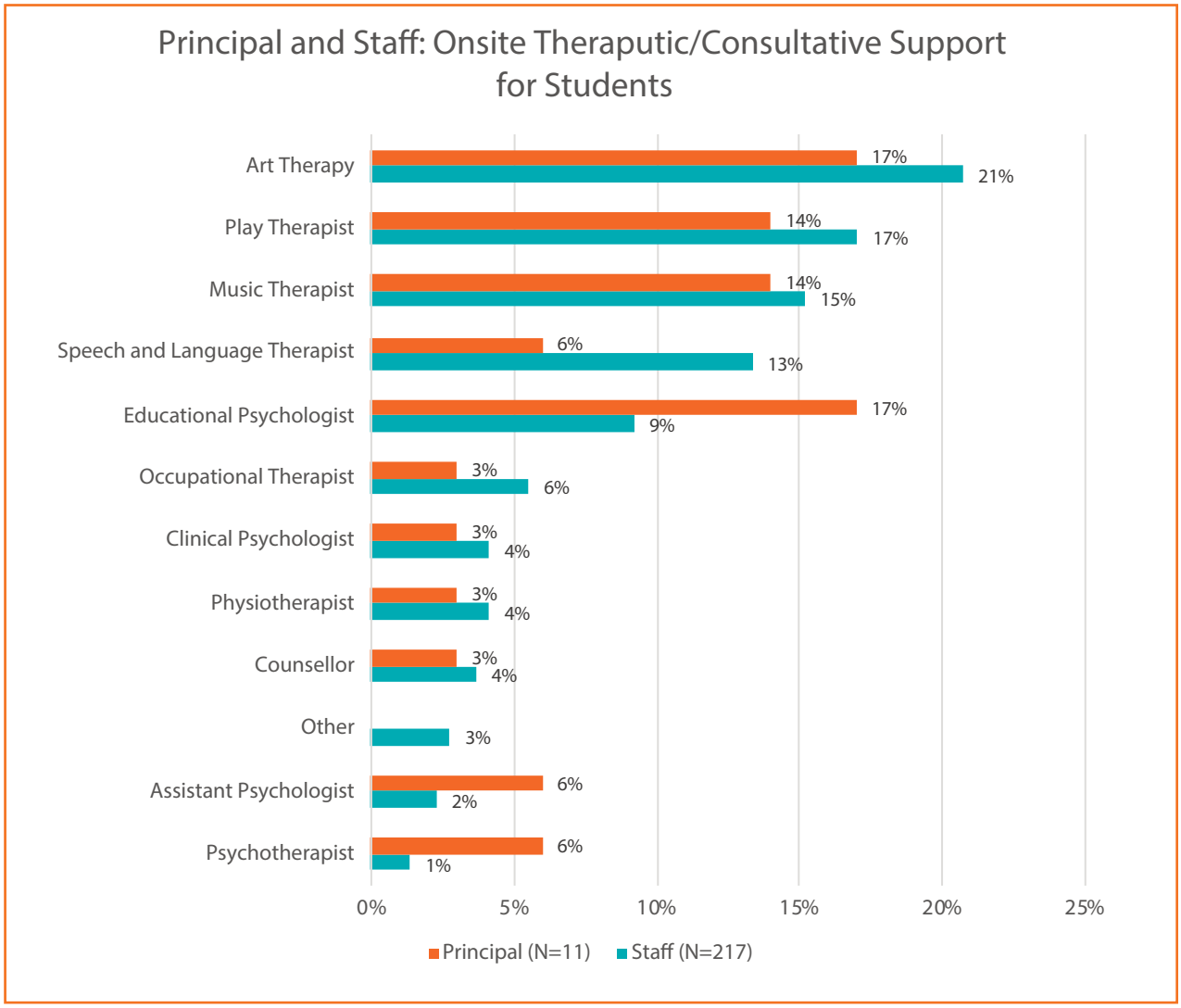
Current levels of onsite multidisciplinary support

Survey data

It was clear from the principal and staff surveys that there is already an established practice of multidisciplinary professionals working onsite in the Oscailt schools that participated in the research. The majority of principals (91%) and staff (69%) indicated that their students had access to school-based multidisciplinary professionals in a therapeutic and/or consultation context i.e., not just for a once-off observation or assessment.

Chart 28 details the range of multidisciplinary professionals working in a consultative or therapeutic context including art therapists, assistant psychologists, clinical psychologists, counsellors, educational psychologists, music therapists, occupational therapists, physiotherapists, play therapists, psychotherapists and speech and language therapists. The multidisciplinary professionals most based in schools according to principals are art therapists, play therapists, music therapists and educational psychologists. **Chart 19** in Part 1 already indicated that Creative Therapies and NEPS were ranked in the top four most prevalent service areas of need identified by principals and staff. These are also the areas that schools fundraise in order to provide support for students. Blue Box or SCP provide limited support around Creative Therapies. Staff survey responses were largely in keeping with principal responses. However, 13% of staff in comparison to 7% of principals indicated that speech and language therapist support was available onsite and only 9% of staff in comparison to 17% of principals indicated that education psychologist support was available onsite. As detailed in part one, these differences may be related to principal knowledge of sensitive information about students and responding to questions based on all students in the schools. Staff are more likely to be responding based on knowledge and experience of particular groups of students.

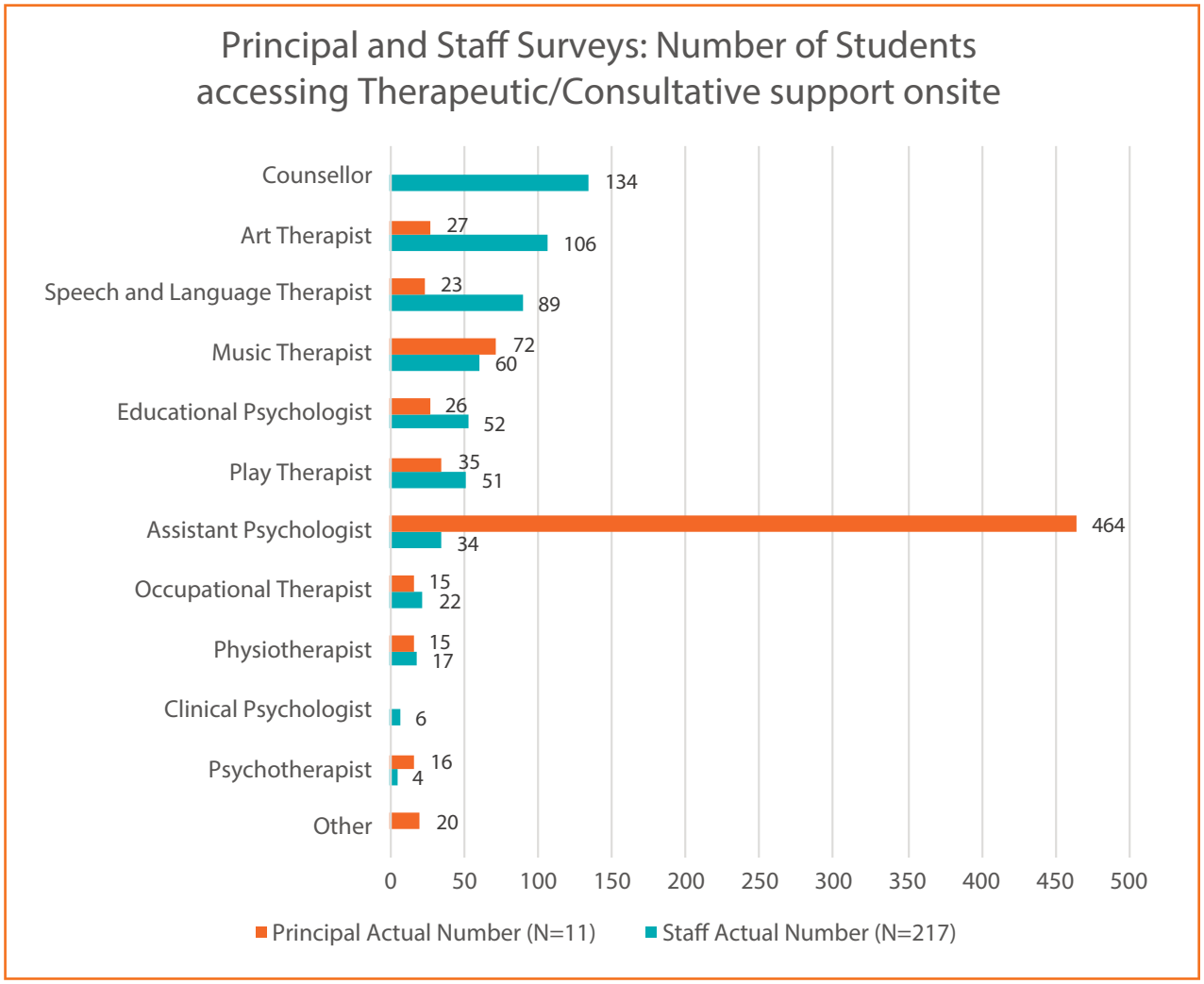
Chart 28 Onsite therapeutic/consultative support for students



Interestingly, Art Therapy is listed as the onsite support most available in schools by both the principal and staff surveys. However, when surveyed on the number of students availing of therapeutic and consultative services (excluding assessment and observation), according to staff the highest number of students were availing of the support of a counsellor (N=134), followed by Art Therapist (N=106 students).

Assistant Psychologist was the service available to the highest number of students (N=464) according to principals, which reflects the availability of an Assistant Psychologist to all students in one school, as opposed to several schools having access to same. This service was followed by Music Therapy (N=72), Play Therapy (N=35) and Art Therapy (N=27).

Chart 29 Number of students in receipt of onsite therapeutic/consultative support



Feedback from principals and staff focus groups

It was evident that onsite delivery of multidisciplinary support is quite varied across the schools depending on the resources available to the school e.g., through fundraising or the SCP, through the collaborative initiatives that they are involved in with other stakeholders or community organisations, and whether multidisciplinary professionals from the statutory service providers will deliver onsite in schools or just in clinic-based settings.

Blue Box, Barnardo's, Focus Ireland, Jigsaw and School Completion Programmes are just some of a range of organisations school staff cited that schools currently link with to provide onsite services such as Creative Therapies.

Some schools indicated that they have speech and language therapy provided by the local primary care centre. However, this is very dependent on whether staff from the relevant primary care centre provide onsite support in schools. Staff focus group participants observed a lack of consistency across the city on

whether primary care services are delivered in schools or not. In some schools, a therapist from the local primary care centre will do an assessment and deliver a block of intervention in the school, but this varies. Similarly, a number of principals indicated that while an observation may take place in school, they do not have any onsite service delivery or *'actual services'* (Principal 7) from statutory services, which they find hugely frustrating.

Lack of continuity in current onsite provision was highlighted as a concern by staff focus group participant. A child may receive a short block of an intervention e.g., SLT and then the case is closed. Several participants highlighted the tokenistic nature of support, where children receive only short-term interventions that do not address their long-term needs.

With parental consent, some services will copy the school on children's appointment details, but this can depend on the policy of the individual service or the relationship the school has with an individual therapist.

If parents miss an appointment with a service, the child can be struck off the list and the school may not be aware of this.

- Children can time out of services chronologically at a certain age (e.g., 8 was mentioned by a few participants in relation to autism).
- A lack of joined up thinking and communication between services on how to best meet the needs of children was reported and children are getting lost in the system as a result.

During data collection, some schools indicated that they were participating in the HAPPEE[20] project. In the 2023-2024 school year HAPPEE delivered Occupational Therapy, Physical Therapy and Speech and Language Therapy interventions in six schools through student placements from the School of Allied Health in UL with onsite clinical supervision. Full details are shown on **Table 13** below. Findings from an evaluation of HAPPEE (Hickey 2025a) reveal a 98% attendance rate for appointments.

Table 13 HAPPEE interventions 2023-2024

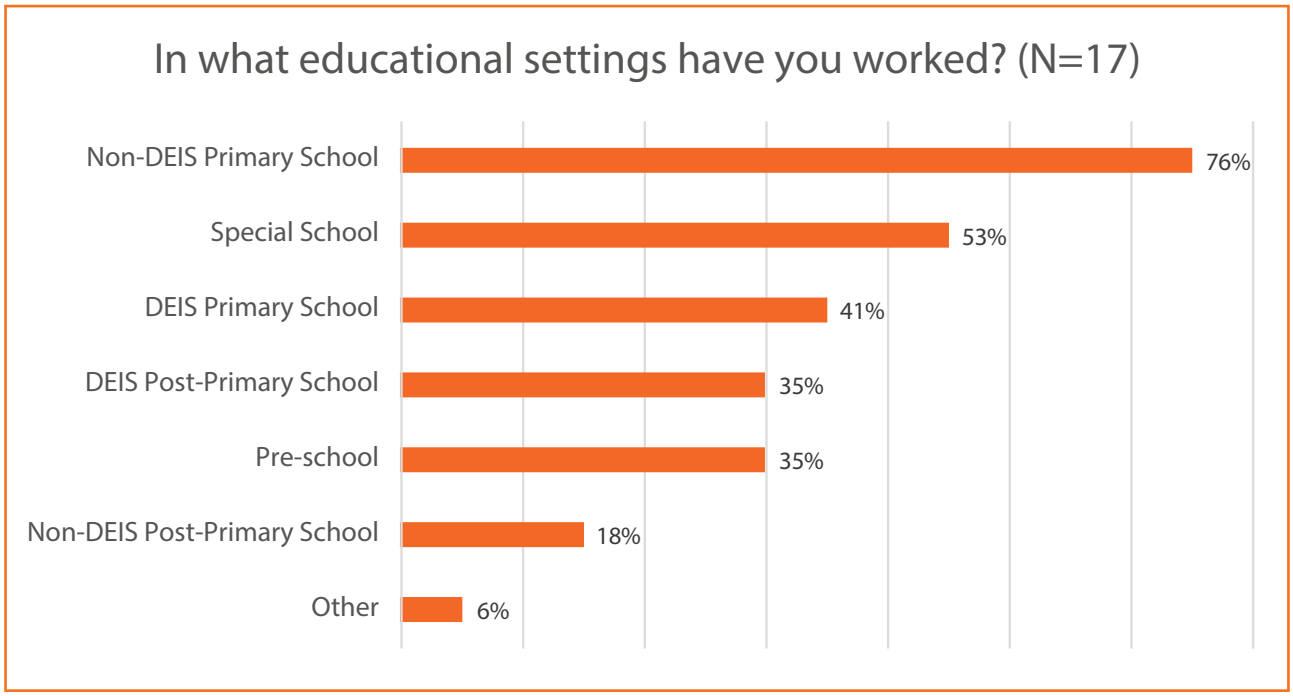
	Occupational Therapy			Physiotherapy			Speech & Language Therapy		
Timeframe	**Universal**	**Targeted**	**Individual**	**Universal**	**Targeted**	**Individual**	**Universal**	**Targeted**	**Individual**
Aug-Dec 2023 (2 schools)	315	24	2	122	36	17	90	34	11
Jan-Jul 2024 (6 schools)	332	116	23	91	98	16	80	28	13
Grand total Yr 1	**647**	**140**	**25**	**213**	**134**	**33**	**170**	**62**	**24**

[20] *Detailed Section Three.*

Survey findings and feedback from Multidisciplinary Professionals

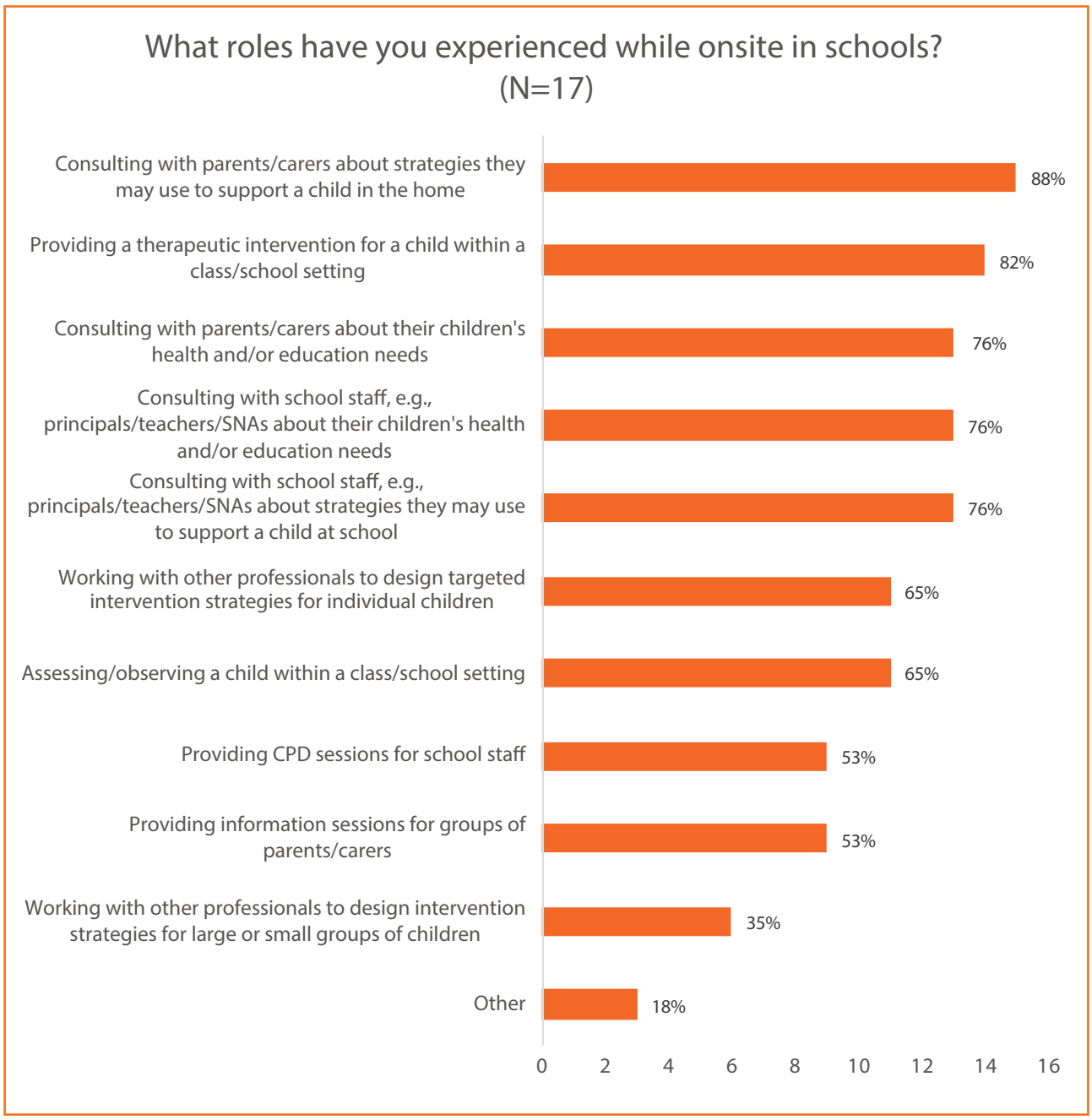
The majority of the 28 multidisciplinary professional survey respondents (61%) indicated that they had experience of working onsite in an educational setting with children. Interestingly, as **Chart 30** reveals, the majority of these experiences were in a non-DEIS primary school (76%), followed by special schools (53%), DEIS primary schools (41%) and DEIS post-primary (35%).

Chart 30 Multidisciplinary professionals experience and type of educational setting



When asked about the types of work they carried out in schools, the majority (88%) of multidisciplinary professionals indicated consulting with parents/carers about strategies they may use to support a child, followed closely (82%) by providing a therapeutic intervention for a child in a class or schools setting. Other experience included consulting with parents about their child's health or educational needs (76%), and a providing a range of consultation with school staff (76%). Multidisciplinary professionals also equally reported that they worked with other professionals to design intervention strategies for children in educational settings and assessed/observed children within a class/school (65%). Just over half (53%) had provided CPD sessions for school staff and provided information sessions for groups of parents or carers.

Chart 31 Role of multidisciplinary professionals in schools



How schools refer students for multidisciplinary assessment and support

During the data collection, it was apparent that the referral process for multidisciplinary support and assessment is complex, and many commented that for parents in particular, the process can be quite difficult to understand and navigate.

Schools refer students to a variety of services delivered by statutory agencies and non-statutory agencies. They also find creative ways of accessing support for students. Referral pathways for support depend on whether the service is 1) clinic-based and delivered by a statutory agency, 2) school-based and delivered by statutory agency, privately by the school or by a community organisation or 3) community based and offered by a community organisation. The referral systems for statutory clinic-based services were reported as being more complex by multidisciplinary professional focus group participants, and as having long wait lists. While they described school-based referrals as more straightforward and immediate, their needs-based structure meant that there were limited numbers of children who could participate and hence, wait lists still existed. Staff focus group participants emphasised the complexity and myriad of challenges involved in the process for accessing support through statutory agencies. Principals outlined how they support children as best they can through applying the Continuum of Support:

> *'So, there's a three-pronged approach. The whole class approach, and then you look at small groupings where children with similar needs are put into groupings and the working together with them and then the final approach then is that specific approach, maybe be one to one or two to one approach around the child as well'* (Principal 11).

For most schools, the general referral pathway for staff members putting students forward for multidisciplinary support and/or assessment is through the Special Educational Needs Coordinator (SENCO) or the principal and in keeping with the Continuum of Support - School Support Plus:

> *'If there is a concern … the class teacher will usually* [bring it] *to the school principal or to myself, who works as the head of SEN and would inform us of their concerns… We'll see what we can do here at school and then what we do next is to fill in … a referral'*
> (Teacher School 1).

Once the SENCO or principal has been informed the schools complete a form for the relevant service (SLT, OT, Physiotherapy, Psychology etc.) or services (for students who may need multidisciplinary support) and this is sent to the HSE. The referral is carried out in consultation with the parents who contribute to completing the referral form. The HSCL can also be involved in the referral process, with one multidisciplinary professional reporting that *'We get paperwork that's completed by the HSCL and then paperwork that's completed by the teacher. Then there's a meeting with the parent'* (Multidisciplinary Focus Group 1 SP3).

In addition to the supporting the AON process schools can also refer directly to the Primary Care Team and CDNT, which is a new more direct method of referral: *'You can refer children now directly to the services, so you don't need to go through the assessment of need process'* (Principal 7). While many schools have welcomed this *'simpler referral process',* it is reported that this change has caused additional problems of its own:

> *'Speaker 1: The way the referral process has changed now that you can refer directly into each agency … has created its own issue because* [the child] *could be referred into one* [agency] *waiting 18 months* [to then be told] *'no, you're not a fit' and then referred into* [another agency] *for 18 months. Possibly not a fit there either'* (Teacher School 13).

Schools face difficult decisions in light of limited resources and high level of need, with some feeling like they are *'playing God'*.

> *'It's heart-breaking. Because I sit down with the SEN Coordinator in the school, I sit down with her team and we go,' OK, these are all the kids and we have now and all of the general students support files, individual education plans. Let's get our priority files' and you're literally … You're very, very quickly having to make a decision on who's going to get support and who's not … We know those five really need it and those 20 don't, there's about 25 that absolutely need it, and we can pick three. So, like you're literally playing God'* (Principal 6).

For needs or concerns which relate to mental health or a potential mental health condition, a referral to CAMHS via the student's GP is required: *'The one we can't refer to would be CAMHS'* (Principal 4). Some principals cited this indirect referral process as somewhat of a challenge as they feel CAMHS might be keeping them at a distance: *'I don't know if it's an appropriate way to say,* [CAMHS] *keep schools at arm's length, but they have become I think in some cases a little bit more open'* (Principal 4). However, one school relayed an example of CAMHS working onsite, as the community-based service was not a feasible option due to family circumstances.

Schools can also engage with NEPS through a *'request of intervention referral'*. However, there are varying levels of service provided by NEPS with one school reporting that they did not have any NEPS psychologist assigned to the school for three years. At the time of interview, another school indicated that they were also without access to a NEPS psychologist and were relying on the Scheme for the Commissioning of Psychological Assessments (SCPA). Feedback from principal interviews and staff focus groups highlighted the urgent need for a far greater number of NEPS assessments per school than currently allocated, which was cited as being 2-3 assessments per school per year in most cases.
In other situations, some referrals are made within the school context depending on the service being sought:

> *'Within the school, I meet with individual teachers and go through a list of kids to figure out who are the bigger needs once at the start of the year and again in January. We decide who might be fitting for the group work and who might the fitting for the individual sessions and then we involve parents'* (Multidisciplinary Focus Group 1 SP1).

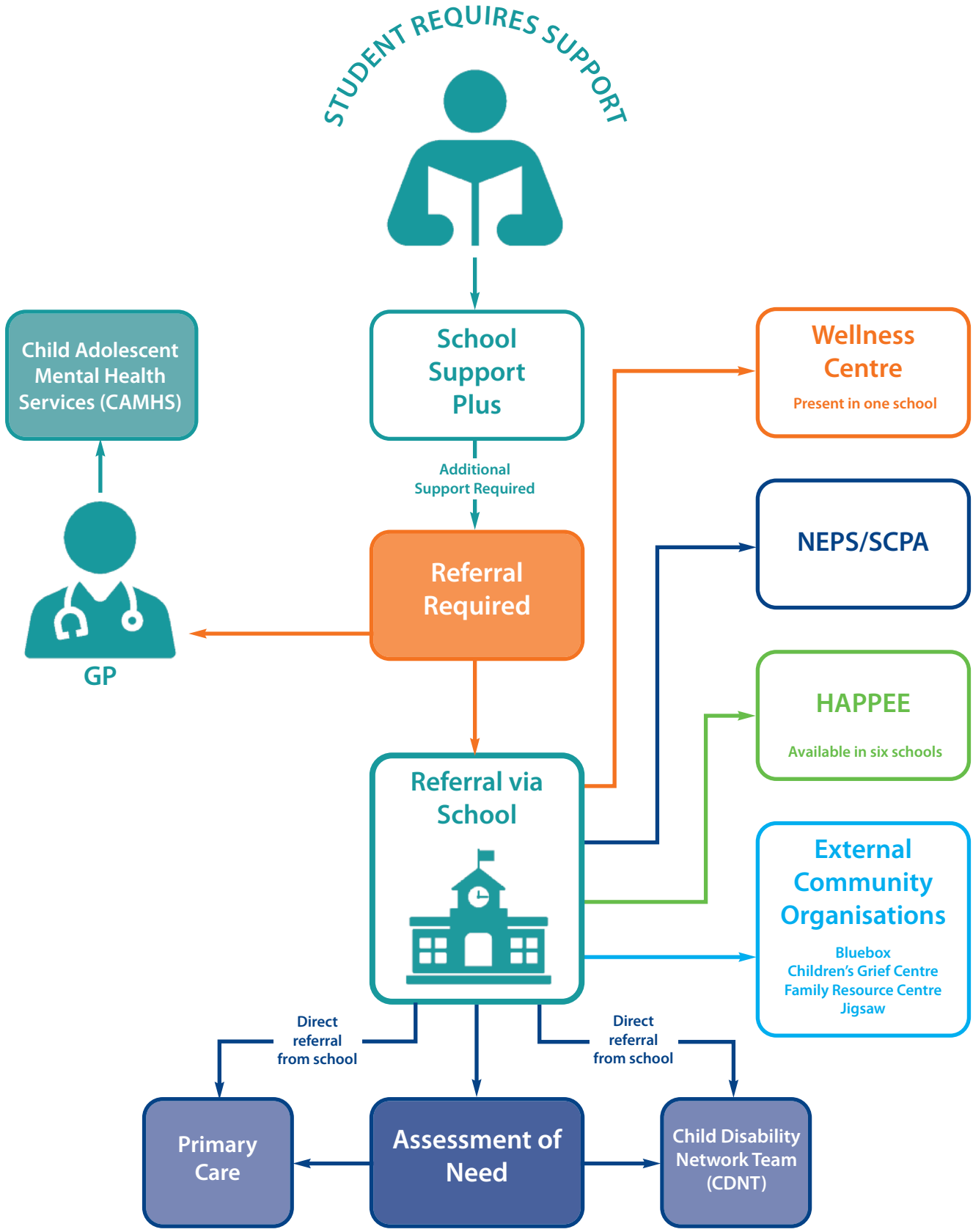
One school has a wellness centre attached to the school that provides psychological and therapeutic support for children and parents. In this school, teachers highlight concerns about children with the Care Team who review and decide whether the child needs to be referred internally or externally. This school also participates in the HAPPEE project. The Clinical Psychologist based in the wellness centre meets with parents to discuss referral of children if their needs are in this area. This school also refers to primary care and other supports depending on the needs of the child. In some instances, teachers might refer both internally and externally but hope that the child will be seen quicker internally.

Some schools also have specialised classes for language support that HSE staff support. However, principals felt additional supports like occupational therapy and speech and language therapy were required for special classes: *'So, a teacher will do their best inside there, but it just needs to become part of on the ground school support and it just has to be a given rather than a luxury'* (Principal 9). Some school's management boards support staff to upskill to be able to better support children in the absence of services.

Schools also reported trying to access the services the students need in creative and innovative ways such as using their teaching allocation to get a psychologist or sharing resources and facilities with neighbouring schools so that all children can access support.

Additionally, schools refer and link students and parents to non-statutory or community and voluntary agencies that they work with such as Blue Box, Family Resource Centres, or the Children's Grief Centre, who provide Creative Therapies or therapeutic support for children.

Figure 4 School based referral processes



Feedback on referral processes and accessing support

Across research participant groups, feedback primarily focused on the significant challenges and barriers for children, parents and schools in accessing off-site services. These are detailed below. For the school who has an extensive range of services available on site, their referral system was reported in the staff focus group as working well and involving *'very little referral outside of school at this point'.* Of the parents who were interviewed only one parent acknowledged that they were *'lucky with services'* (Parent Interview 10) because their child has always had access to services since diagnosis.

Challenges with the referral process and access to support

A myriad of challenges emerged from focus groups, interviews and surveys in relation to the referral process and access to services. These stem from logistical challenges and systemic issues such as long wait times and complicated referral processes. The data emphasises the complexity of the issues and many voiced frustrations over the current system's limitations, lengthy wait lists, the referral system and their impact on children's well-being. The referral process is seen by principals, staff and parents alike as complex and confusing. A key issue highlighted in relation to NEPS was the complete absence of a wait list for the service as it does not maintain one. However, schools indicated that they maintained their own list of students in need of education psychology assessments which was far greater than the minute number schools are assigned each year.

Challenges cited across accounts with referral processes and accessing support include lengthy wait lists for referrals, confusion and complexity of the referral process, and challenges with parental engagement and for parents themselves with the referral process.

Lengthy wait lists

Lengthy wait lists were highlighted by parents, principals, school staff and multidisciplinary professionals as a significant challenge, with reports from parents of children being on wait lists for up to four years and schools and multidisciplinary professionals citing wait lists of up to two to three years. Some of the participants in staff and parent focus groups identified lengthy wait lists and lack of access to services as their greatest concern for children because children are getting lost in the system.

School staff and principals indicated that many parents simply cannot afford to pay for private assessments or services, and this is a contributing factor to lengthy wait lists. Only two parents interviewed indicated that they had paid privately for reports and services and outlined the significant costs involved. One parent shared that they had to pay for an assessment because their child would be waiting two to three years to be seen publicly otherwise. The majority of parents interviewed had children seeking assessments or services in the public system and expressed deep frustration with the length of wait time associated with the referral process, as evident below:

> *'My child was referred to services at 18 months and seen just under the age of three. Then we waited two years to see a psychologist. I still to this day do not know what's wrong with my child. I have no access to services. We were told the waiting list is three to four years. How can I support a child when I don't know what's wrong?'* (Parent 1)

Another parent revealed that their child '*is on a waiting list for four years for speech and language* [therapy]' (Parent 3) and a second parent shared that their child had not received any support from services since being diagnosed in 2021 and '*the school have taken on the role of the disability services'* (Parent 4). Parents identified a range of challenges they currently face accessing clinic-based services with all bar one stating it was impossible to get an appointment. One parent declared that a particular service is *'a dead service'* (Parent12) and another described a service as completely *'overloaded'* (Parent 5).

School staff and multidisciplinary professionals shared parents' frustrations with wait lists, with one principal stating *'I've never seen wait lists so bad'* (Principal 2). Most schools highlighted significant wait times of 15-18 months on average, with waits of up to three years in some cases for assessments or for services to be delivered through Primary Care or the CDNT. They emphasised the impact of COVID on wait lists. Currently, going through the public system involves a two to three year wait for an initial assessment '*never mind to get a referral'* (Principal 3). This was echoed by a multidisciplinary professional who stated that :'*There is a two and a half year waiting process at the moment for an assessment'* (Multidisciplinary Focus Group 1 SP2). In one instance a staff member reported a student who was is now eight years old and had not been seen since they were two as detailed in the following quote:

> *'A lot of my children would have been diagnosed and nothing come of it. And I have one of them that hasn't been seen since he was two. He's now eight and the advice that we have been given, they don't know the child, it doesn't reflect the child. It's just general advice'* (Teacher School 7).

At primary level, senior school staff highlighted difficulties they encounter as children only come to them from 2nd to 6th class. If the schools refer children for services, they're *'nearly gone from the school'* (Principal Interview) by the time the services get back to the school.

Parents, school staff and principals highlighted several challenges with services such as being underfunded and overly stretched as reasons for delays in referral and a factor of lengthy wait lists:

> *'There's a huge amount with speech and language again, the physio, the OT and we're constantly referring, like within every class there's referrals to primary care but what we're finding is that primary care don't have the resources, CAMHS don't have the resources either to meet the needs'* (Teacher School 6).

Multidisciplinary professionals also highlighted the strain and negative impact that waiting times are having on service delivery:

> *'We're in schools four days a week and we're seeing 70 children a week so there's 70 families across Limerick City that we're supporting and yet I've a huge waiting list as long as my arm, as do the schools. So, there is a clear need for intervention to happen and the earlier it happens the better'* (Multidisciplinary Focus Group 1 SP3).

Where children do receive onsite support, some principals and school staff relayed concerns about the inadequacy of the level of service provided through a six-week *'tick the box exercise'* (Principal 6) which does little to meet children's needs.

Staff focus group members relayed that schools, and often parents, are constantly ringing and chasing up referral forms with various services and where there is little interaction with schools, children can get lost in the system.

One school staff member shared their belief that services are deciding not to see some of the children in person in some instances as a direct result of lengthy wait lists as evident below:

> *'Even at the minute the lists are so long that they are actually making decisions of not seeing children. It is based on what is coming in front of them … the paperwork mightn't be phrased strongly enough … So, they don't even get to that stage of meeting the child to have that assessment. And then, if you do, you're on an 18-month waiting list'* (Teacher School 6).

Due to the extensive and *'crazy'* wait lists, schools are often forced to find *'interim'* solutions, such as privately funding assessments or services through philanthropic donations. This puts pressure on schools to raise funds and an additional strain on school resources, and while it may provide temporary relief, it is not a sustainable solution.

> *'At times we try to fund things privately as an interim measure… but we're not solving it until a waiting list can be freed up'* (Principal 1).

Some principals relayed that schools often resort to making multiple referrals in the hope that children can access some service. One principal observed the need for a *'plan B and a back-up'* (Principal 12) and advised it was better for the child to be on two wait lists.

Staff not being replaced in NEPS or HSE services when they go on sick leave or statutory leave is a significant issue which is also believed to have an impact on wait times in relation to referrals and often a referral form '*is actually sitting on someone's desk waiting there, you know, because someone isn't being covered or someone's on maternity* [leave]' (Teacher School 8). This seems to be a common issue for schools

who report frustration with referrals not being passed on to other relevant professionals when HSE staff are on leave, as expressed in the following quote:

> *'Speaker 1: But why was it not handed over to someone else? And even after it got handed over to somebody else, there was a break of nearly four or five months before we heard anything back again'* (Teacher School 8).

On the new direct referral process, school staff reported that the new forms are '*a huge block for our school'* (Teacher School 10). While the HSE acknowledge the referrals in a timely manner, they are often notifying the school that the child being referred has been placed on a waiting list as opposed to notification of an assessment or service delivery:

> *'The HSE are very quick to come back to say what they have to say but very often that is 'Thank you for referring this child on, they've been placed on a wait list. Please note that there is a very long wait period'* (Teacher School 1).

A complex system that is confusing and difficult to navigate

The complexity of the new referral forms was a key concern highlighted across participant groups. One multidisciplinary professional relayed that the new systems are '*so complicated trying to refer a child to the disability team'* and that *'the referral forms are twelve pages long'* (Multidisciplinary Focus Group 1 SP2). Staff focus group participants also emphasised how detailed the new referral forms are with a new *'level of depth'* and *'somewhat sensitive information'* (Teacher School 11) which creates an additional *'layer of bureaucracy'* attached to them. Changes to the level of detail required in the forms are a challenge for school. Additionally, school staff shared their fears that forms *'languish'* on desks in statutory services if there is a mistake in the form or they are sent to the wrong place, rather than being sent on to the appropriate service. This was viewed as leading to delays in children accessing services.

One staff member highlighted a challenge that occurs when children are referred to the CDNT, stating that in these situations they cannot receive services through Primary Care, which are often delivered within the local community or within the school:

> *'So, if they're diagnosed with autism, they're part of a Blackberry Park cohort, let's say, they then can't access services in the community. So, they can't go to the local speech therapists, or they can't go to local OT or physio because they're within the multidisciplinary team, which I think is massive. So, there are children here that have significant speech and language issues and concerns, but because they're on the multidisciplinary team list, they can't access these services. They're not getting supports with multidisciplinary because they don't have them, so they're not getting speech therapy or OT and they are completely lost. I think it's absolutely shocking'* (Teacher School 13).

In one school, staff highlighted that Primary Care services used to work together but had recently split into their own divisions, which subsequently impacted on children getting support while the services were re-established.

Principals also reported confusion and difficulty with the referrals process as there are such a multitude of pathways to refer students onwards for assessment and support:

> *'Confusing is the best way I can put it, there are so many different services out there, so many paths to different services. And then, even within those paths there are so many follow ups, you know, and then there's so many wait lists and then people become frustrated, and they try two or three different paths at once'* (Principal 1).

A variety of other concerns with the complex referral process were highlighted by school staff focus group participants including the amount of time and resources school staff invest in the referral process. School staff emphasised the support work they do to ensure children are referred to services e.g., meetings, sharing information, filling out referral forms, writing letters on behalf of the family. As such, they felt it does not make sense to remove schools from the process once the referral is made. Schools and often parents, are constantly ringing and chasing referrals with various services. With parental consent, some services will copy the school on children's appointment details, but this can depend on the policy of the individual service or the relationship the school has with an individual therapist. If children are referred to CDNT, they cannot receive services through primary care, which are often delivered in the local community or school. If children do not have the necessary paperwork before they transfer from a junior to senior school or at the end of primary, they can have trouble accessing support in the senior school or post-primary. One school staff member shared that a therapist requested to meet with them to do a review of a child but did not see or provide any intervention for the particular child referred to the service. The child was subsequently taken off the waiting list on the basis of the talk with the teacher. Instances were cited of CAMHS indicating that a child does not meet their criteria, and that the child should be referred to a different service only for parents to be advised by the subsequent service that the child should be seen by CAMHS.

For autism classes, children need a diagnosis from a psychologist, but the paperwork does not always include a recommendation for an autism class. Trying to get this retrospectively can cause a lot of issues for children, who may need to be reassessed.

Finally, parents are sometimes offered a course on a particular topic by the CDNT rather than a service or intervention for a child. If the course is considered to be at a *'low level'* e.g., sleep training or toilet training, and not a priority in relation to the child's needs, parents may not attend, and the child is subsequently struck off the waiting list for services.

Not surprisingly, a complete lack of joined up thinking and communication between services on how to best meet the needs of children was reported with children getting lost in the system as a result.

Barriers to attendance at off-site/clinic based multidisciplinary appointments

Parental consent, involvement and engagement are an essential part of the referral process, and the schools involved in the research outlined in detail the extent of the support they provide for parents in this regard (see Part 1). However, this factor poses a significant challenge for schools and parents themselves as well as for services. It was evident from research participants accounts that non-attendance at appointments is complicated and parents, principals and school staff focus group participants identified several barriers to parents bringing children to appointments in clinic-based settings which can result in missed appointments and further delays for students' access to supports.

Transport was recognised as a significant issue, especially if parents are reliant on public transport, as many are, or if they must go to other parts of the city for appointments. As one parent observed, '*Definitely it is a challenge, and I drive but other parents don't and some of the services are not within their range so it's hard to get there'* (Parent 5). Another shared that if using public transport *'you're adding another hour and a half to the length of time you'll be away'* (Parent 6). Parents may have other children to look after or collect from school, may not have childcare or may be working at appointment times. Parents also acknowledged how difficult clinic-based appointments can be for their children as they are out of their comfort zone or overstimulated as evident below:

> *'The kids are missing school and they're out of their comfort zone going to somewhere they've never been. It's a daunting place for them - I don't think it's right'* (Parent 1).
> *'Finding time to get off work and the child is going to be disrupted from class, brought in a car to an appointment where you could be stuck in traffic. Then he gets overstimulated and refuses to engage and even when you do show up you get no benefit because he refuses to engage'* (Parent 2).

Principals and school staff outlined a variety of other barriers emphasising that some parents may lack capacity to engage due to personal circumstance such as mental health issues, domestic violence, being in crisis or living chaotic lives and thus struggle to organise themselves or prioritise appointments. Families may be homeless or living in emergency accommodation and not receive their letters if they go to their previous address, or some parents do not give the address where there are currently staying for a variety of reasons, including personal safety.

> *'After* [supporting parents with the initial referral], *a lot of responsibility lies on families to be receiving letters/phone calls when they are not in safe accommodation or regularly change phones or don't have credit. Even if we successfully get an appointment date, families don't/can't always prioritise the pre-meetings and often get put down as Did Not Attend or Can Not Attend or are removed from waitlists'* (Staff Survey Quote).

Additionally, parents may be under financial or other stresses, may be overwhelmed or have multiple children on multiple wait lists and be *'exhausted from it all'* (Teacher School 11).

Lack of trust in services was cited as a key barrier as some parents may have had negative prior experiences themselves with services or may not have established relationships with professionals in services. Some may lack confidence or feel their parenting will be judged or feel *'unsafe'* attending appointments in unfamiliar environments. For some, multidisciplinary professionals may be viewed as intimidating *'authority figures'*.

> *'Speaker 3: I think they can kind of feel judged. I know one of the parents of a child in my class just felt that they were judged, and I was like 'No, it it's help, they're trying to help you', you know'* (Teacher School 2).

Several principals and school staff noted that a referral to a service can become invalid or delayed if parents do not follow through with the necessary steps, such as completing additional forms or attending appointments. At times the success of a referral relies heavily on parents, who may not always have the capability to comply and school staff expressed concern about the exclusion of schools from the referral process. This lack of communication between schools and services means that critical information about the child's needs may be missed, resulting in incomplete assessments and interventions. Parents may not see the value of appointments, lack understanding of what the service does, how lengthy the wait lists can be and the need to attend *'lesser appointments'* in order for their child to receive an intervention. As a result, during the referral process parents can sometimes disengage, which can halt the referral process and create delays in children receiving support as they '*are often discharged for non-attendance (understandable) and then have to begin a long path to re-referral to start the process again'* (Principal Survey Quote). To compound the challenge of wait lists, schools also report that some of their referrals can be made invalid if the child's parents do not follow up after the school has engaged in their part of the process. Low literacy or receptive and productive English language skills, lack of translation support and the amount of complicated paperwork often required were identified as significant challenges for parents, in addition the requirement for sensitive information and complicated pathways for services:

> *'We're asked to fill up a referral from here. We send that off. They then send an extra piece of an extra application form sent straight to the parents. They asked the parents to fill in with more information and often the parents don't have the skill set to even fill that in and then we'll get a letter saying that the parents didn't return the forms. So, the referral doesn't go through, back to square one* (Principal 6).

School staff reported that the new HSE referral forms are posing a challenge for parents as '*It's gone from a simple page to booklets. The HSE referral, they don't make it easy for parents'* (Teacher School 6). Some parents may find the referral process challenging as a result and may need support from school personnel such as the HSCL:

'We're either DEIS band one or we're kids from other nationalities where the parents English would be poor on both sides of it. And the forms are just so hard for the parents, like even the Barnardo's self-referral form, like we wouldn't have the parent able to fill it out with themselves' (Teacher School 10).

Sometimes children lack capacity to engage if they are tired or do not want to attend. One principal observed that some of the centres in which services are offered are not child friendly, '*look like jails*' (Principal 11) and can be intimidating for children further hindering engagement. On rare occasions, a parent may decide the child does not need to attend the service. Older children e.g., at post primary, may not want to attend or may be dictating to parents what they will do. Stigma in relation to mental health can be a barrier to parents taking children to appointments as can stigma around SEN.

Case studies of children referred for multidisciplinary support

The following four case studies of students[21] who need multidisciplinary support are drawn from across the accounts relayed by parents, school staff and multidisciplinary professionals in interviews and focus groups to illustrate various experiences of accessing multidisciplinary support for children, the challenges in the current system and the subsequent impact on their health and wellbeing and academic outcomes.

[21] *The names used for the case studies are from the CSO list of popular baby names in 2024 and are not connected to any of research participants* https://www.cso.ie/en/releasesandpublications/ep/p-ibn/irishbabiesnames2024/ .

Case Study 1 - Amelia, Age 7

Amelia is a 7-year-old girl living in a socioeconomically disadvantaged area of Limerick. She has been experiencing significant anxiety and behavioural issues both at home and in school.

Possible Pathways

Primary Care/CDNT Services

- **Psychologist:** Amelia could be referred to a psychologist to address her anxiety and behavioural issues. Through regular sessions, the psychologist could help Amelia develop coping strategies and works on her emotional regulation.
- **Occupational Therapist:** Amelia could be referred to an occupational therapist to help her with sensory processing issues that contribute to her anxiety and behavioural outbursts.
- **Speech and Language Therapist:** While Amelia does not have significant speech issues, her expressive language skills could be assessed to ensure she can effectively express her emotions and needs.

CAMHS Services

- **Psychiatrist:** Amelia could be referred to CAMHS for a comprehensive psychiatric evaluation. The psychiatrist would assess her anxiety levels and determine if medication or additional interventions are necessary.
- **Psychotherapy:** Regular psychotherapy with CAMHS would help Amelia address her anxiety in a supportive environment.

NEPS

- **Psychology:** A NEPS psychologist could consult with Amelia's school to provide strategies that may help Amelia with coping skills and emotional regulation.

What Happened?

- Amelia's school has not had access to NEPS services for the last two years so consultation with a NEPS psychologist was not an option.
- A lengthy referral form to Children's Disability Services had to be filled in but Amelia's parents struggle with literacy issues so needed the assistance of the school to complete the form. The school sent the form to the CDNT as they thought this would be the most suitable referral for Amelia.
- The family waited for a number of weeks while the CDNT assessed the referral – the CDNT felt that CAMHS would be more suited to her needs.
- It was not possible for the school or the CDNT to refer Amelia to CAMHS, so her parents had to go to their GP for a referral to CAMHS.
- The GP sent the referral to CAMHS, and the family have now been waiting a year and a half for an appointment.

Outcomes for Amelia

- **Worsening Anxiety:** Amelia's anxiety has worsened without timely psychological support, leading to more frequent and severe physical symptoms including stomach aches and headaches.
- **Behavioural Deterioration:** Her behavioural issues have escalated, resulting in more significant disruptions at school and home. It is likely that this will make it harder to implement effective behavioural interventions later.
- **Academic Struggles:** Prolonged anxiety and behavioural issues have negatively impacted her concentration and performance in school, causing her to fall behind academically.

Case Study 2 - Jack, Age 10

Jack is a 10-year-old boy living in a socioeconomically disadvantaged area of Limerick. He was diagnosed with autism spectrum disorder (ASD). He struggles with social interactions, communication, and sensory sensitivities.

Possible Pathways

CDNT Services

- **Speech and Language Therapist:** Jack could receive speech therapy to improve his communication skills, focusing on both expressive and receptive language abilities.
- **Occupational Therapist:** An occupational therapist could work with Jack on sensory integration techniques to help him better manage his sensitivities and improve daily functioning.
- **Physiotherapist:** Jack could see a physiotherapist to support his gross motor skills and overall physical development.

CAMHS Services

- **Behavioural Therapy:** Jack could participate in behavioural therapy sessions to develop social skills and manage behaviours associated with ASD.

What Happened?

- Although Jack was assessed and diagnosed with ASD by a clinical psychologist on the local CDNT five years ago, he was then on a waiting list for three years for multidisciplinary intervention with the CDNT.
- After three years, Jack got an appointment with his local CDNT. The bus service to the CDNT was very unreliable and his parents couldn't afford a taxi, so his school arranged for transport to the appointments. However, Jack became so upset every time he attended the appointments (as it was an unfamiliar, clinical setting) that his parents stopped taking him.
- CAMHS will not see Jack since he is on a waiting list with a CDNT.

Outcomes for Jack

- **Developmental Delays:** Delays in receiving speech and occupational therapy have resulted in further developmental delays, particularly in communication and sensory integration, making it harder for Jack to catch up with his peers.
- **Social Isolation:** Lack of timely social skills training has increased Jack's social isolation, as he lacks critical support for developing essential social skills. He now refuses to go to school.
- **Increased Family Stress:** Prolonged waiting periods for services have heightened stress levels within Jack's family, as they struggle to manage his needs without professional support.

Case Study 3 - Sophie, Age 12

Sophie is a 12-year-old girl with a history of depression and self-harm living in a socioeconomically disadvantaged area of Limerick. She has been struggling academically and socially, which has exacerbated her mental health issues.

Possible Pathways

Primary Care/CDNT Services:

- **Psychologist:** Sophie could see a psychologist who specializes in adolescent mental health, helping her address her depression and develop healthier coping mechanisms.
- **Occupational Therapist:** An occupational therapist could work with Sophie to establish daily routines and activities that promote mental well-being and reduce stress.

CAMHS Services:

- **Psychiatrist:** Sophie could be referred to a CAMHS psychiatrist for medication management and ongoing psychiatric evaluation.
- **Group Therapy:** Sophie could participate in group therapy sessions with other adolescents experiencing similar issues, providing peer support and reducing feelings of isolation.
- **Crisis Intervention:** CAMHS could provide crisis intervention services, ensuring Sophie has immediate support if her mental health deteriorates.

What Happened?

- Sophie's parents do not speak English, so her school had to liaise with them using an interpreter to fill out an Assessment of Need form.
- It took three months for the Assessment of Need to be completed, and Sophie was then put on a waiting list for CAMHS.
- She has been waiting for over a year to get an appointment with CAMHS.
- Her school then supported her parents in filling out a referral form for the local CDNT to see if that would be a faster route to access support. The CDNT didn't accept the referral as Sophie is already on a waiting list for CAMHS.
- Sophie sees her GP regularly – the GP prescribed medication for depression but it had negative side effects so her parents wouldn't let her continue to take it. The GP is awaiting the expertise of a consultant psychiatrist to advise on the best treatment plan for Sophie.

Outcomes for Sophie

- **Depression:** Without prompt psychological and psychiatric intervention, Sophie's depression deepened, resulting in more frequent and severe self-harm behaviours.
- **Academic Decline:** Prolonged depression and lack of support have led to a significant decline in her academic performance, resulting in disengagement from school.

Case Study 4 - Muhammad, Age 9

Muhammed is a 9-year-old boy diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). He struggles with focus, impulsivity, and hyperactivity, affecting his school performance and social relationships.

Possible Pathways

CAMHS Services:

- **Psychiatrist:** Muhammad could see a CAMHS psychiatrist for medication management to help control his ADHD symptoms.
- **Behavioural Therapy:** Behavioural therapy through CAMHS could focus on reinforcing positive behaviours and reducing disruptive ones in both school and home settings.
- **Parent Training:** CAMHS could provide training for Muhammad's parents to equip them with strategies to support his behaviour management at home.

NEPS:

- **Psychology:** A NEPS psychologist could consult with Muhammad's school to develop strategies for managing his impulsivity and improving his focus.

What Happened?

- Muhammed's school got support from their NEPS psychologist who recommended a referral to CAMHS.
- After waiting for almost two years, Muhammad was seen by CAMHS and put on medication which helped him a lot.
- Recently, however, his family became homeless and moved into a hotel. The appointment letters for CAMHS went to his old address so he missed a few appointments and was discharged by CAMHS.

Outcomes for Muhammad

- **Behavioural Escalation:** Disruptions in behavioural therapy and medication management have resulted in Muhammad's ADHD symptoms worsening, leading to increased impulsivity and hyper-activity that are harder to control.
- **Academic Underachievement:** Muhammad's academic performance is suffering due to persistent difficulties with focus and organisation, which may affect his long-term educational outcomes.
- **Social Challenges:** Prolonged waiting for social skills training has led to ongoing difficulties in peer relationships, increasing the risk of social isolation and associated emotional issues.

Part 3 – A more nuanced understanding of multidisciplinary support onsite in schools

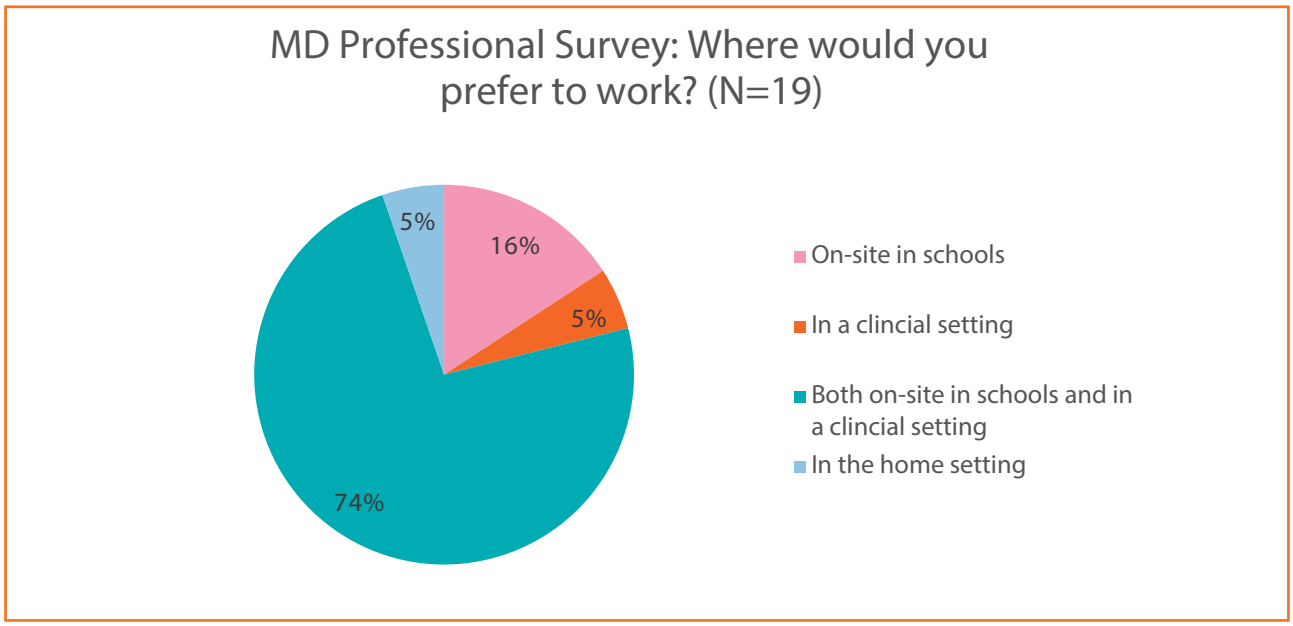
This section explores the nature of onsite multidisciplinary support in schools exploring the perceived and observed benefits and challenges of onsite delivery from the perspective of principals, school staff, parents, children and multidisciplinary professionals. This section also outlines key considerations for onsite multidisciplinary support identified by research participants.

Preference for onsite multidisciplinary support across participants

All principals and the vast majority (97%) of staff survey respondents who answered the question expressed a preference for multidisciplinary teams working on site in their schools. Interestingly, 50% (N=20) of the children who participated in the research were not in favour of onsite delivery for reasons outlined in the next section on challenges.

Chart 32 shows that almost three quarters (74%) of the multidisciplinary professional survey respondents expressed a desire to work both onsite in schools and in a clinical setting, followed by onsite in schools (16%), in a clinical setting only (5%) and in the home setting (5%).

Chart 32 Multidisciplinary professional preference location of work

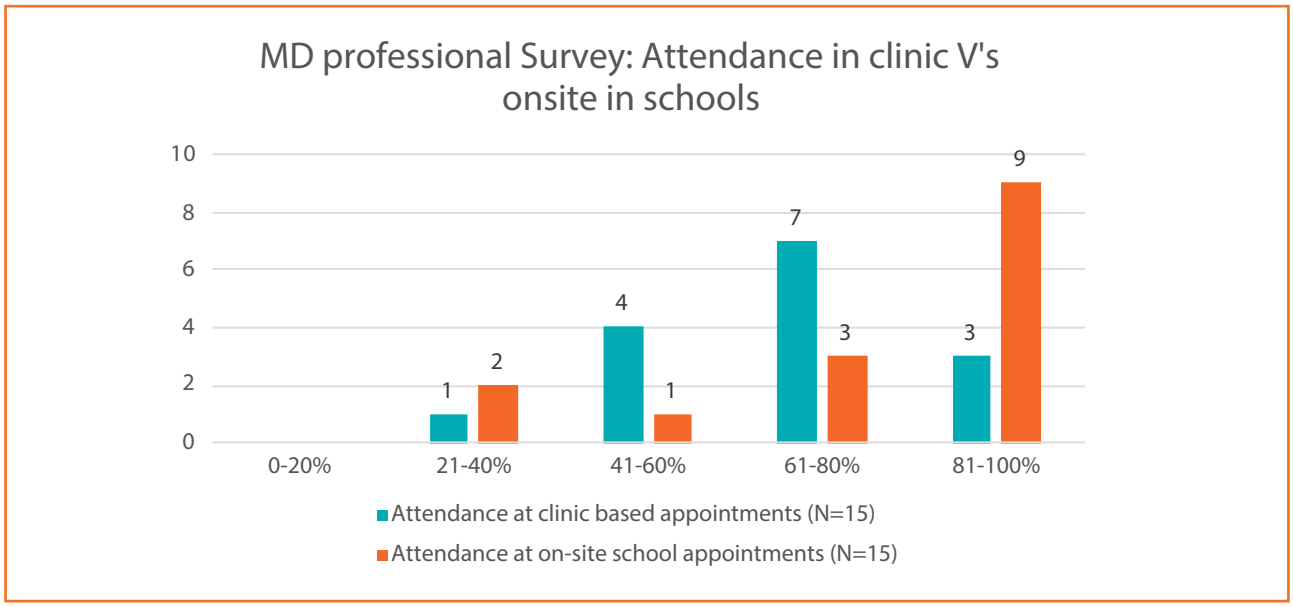


In the focus groups with multidisciplinary professionals, the majority (57%) favoured the school-based only model and 43% indicated a mixture of both. However, the value in both school-based and clinic-based settings was recognised, with clinic-based therapy being cited as important for ensuring boundaries and preventing burnout, as evident in the following quote:

'There's value in both, but we have to protect ourselves as well because we talk about how easy burnout can happen. So, from the therapy point of view, you need the boundaries of the [clinical] *space as well'* (Multidisciplinary Focus Group 1 SP3).

It is clear from **Chart 33** below that multidisciplinary professional survey respondednts experience the greatest level of attendance when appointments are offered onsite in schools with the majority (N=9) indicating that they have 81-100% attendance in schools. Only a fifth of multidisciplinary professionals experience this level of attendance in a clinic based setting. While 7 multidisciplinary professionals reported attendance of 61-80% for clinic based appointments, it is clear from the chart that overall, attendance is greater onsite in schools.

Chart 33 Attendance at appointments in clinic and onsite in schools

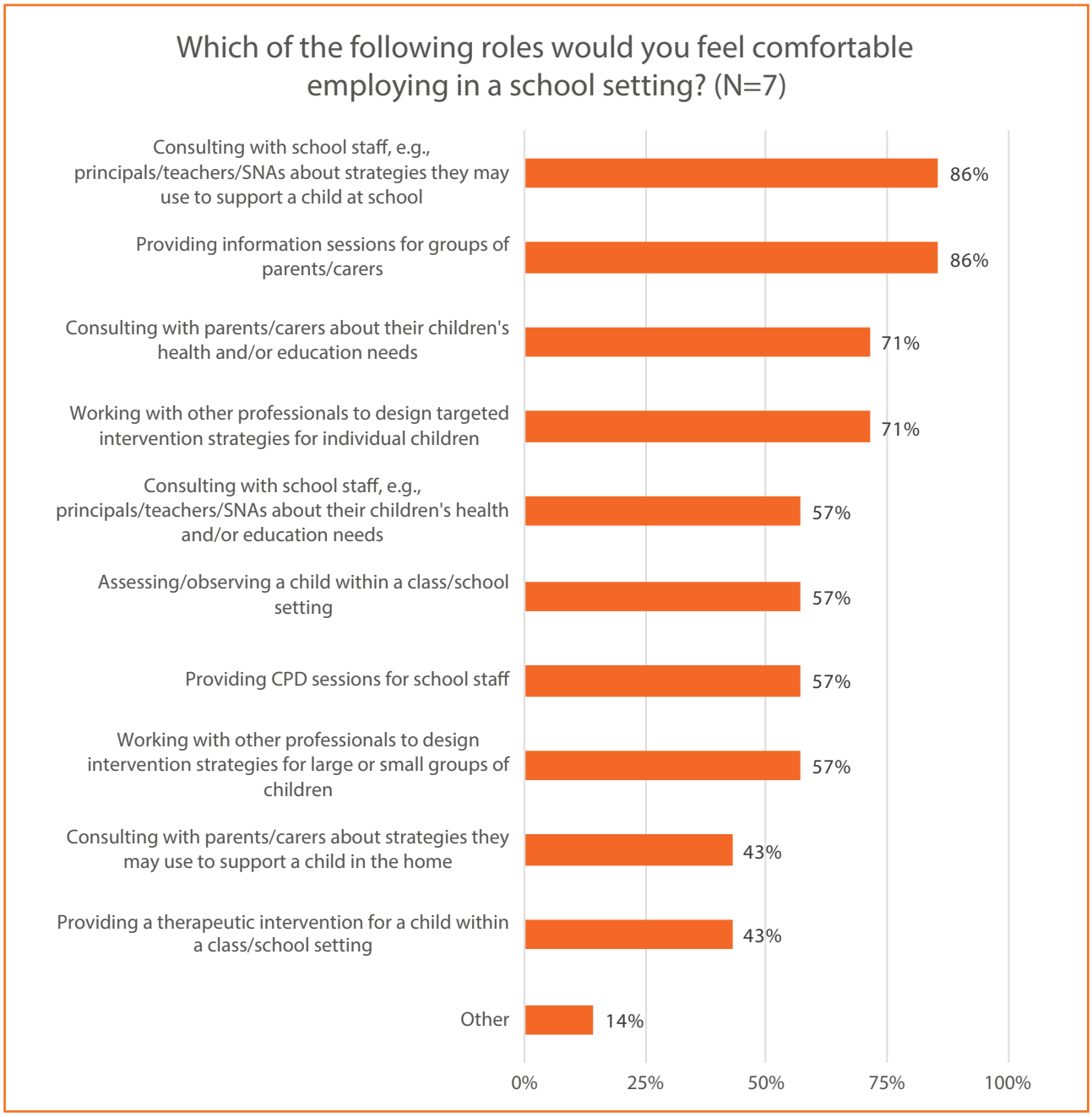


When asked about the types of roles they would feel comfortable employing in a school setting, we can see from **Chart 34** that the majority (86%) of multidisciplinary professionals selected both providing information sessions for groups of parents/carers and consulting with staff about strategies to support a child in school as their first preference. This was followed equally (71%) by consulting with parents/carers about their children's health and/or education needs and working with other professionals to design targeted intervention strategies for individual children. All of the following roles were ranked third at 57%: Assessing/observing a child within a class/school setting, consulting with school staff, e.g., principals/teachers/SNAs about children's health and/or education needs, working with other professionals to design targeted intervention strategies for individual children and providing CPD sessions for school staff.

Multidisciplinary professionals ranked both consulting with parents about strategies they may use to support a child at home and providing a therapeutic intervention for a child within a class/school setting

in fourth place (43%). This is interesting given that the majority of those who completed the question about the roles they have experienced in schools, specified these two items first (see **Chart 31**). Additionally, the majority indicated a preference for school-based delivery and that they experience greater levels of attendance at school-based appointments. It raises questions about why multidisciplinary professionals may feel less comfortable delivering therapeutic interventions for children onsite in schools. Challenges to onsite delivery expressed by multidisciplinary focus group participants may offer some insight on this. For example, issues around lack of dedicated private space for therapeutic support were highlighted and subsequent disruption use of multi-purpose spaces can cause in the school environment and timetable.

Chart 34 Multidisciplinary professionals preferred role in school setting



The vast majority (95%, N=19) of multidisciplinary professional respondents indicated that they communicated with their client's school, with only 1 respondent indicating that they had no communication with the school. Similarly, 95% (N=18) indicated that they had communication with client's parents/carers.

Benefits of providing on site multidisciplinary support.

All stakeholders perceived a range of benefits of onsite multidisciplinary support in schools. However, as outlined previously, half of the children who participated in the focus groups would prefer off-site delivery for a variety of reasons, which are explored in the next section on challenges. One parent was not in favour of school-based delivery due to concern that their child would '*stand out*' (Parent 10) but felt that it should be decided on an individual basis. The vast majority were in favour however and 92% of parents stated that they favoured a school-based system of service delivery including speech and language therapy, occupational therapy, physiotherapy, psychology, CAMHS and other mental health supports. Parents believed that a school-based system would reduce wait lists, provide timely intervention in a familiar setting and would be the '*best possible solution*' (Parent 11). One parent felt that principals and parents would need to be involved in the process of hiring staff for the school-based services to work effectively.

Benefits for children

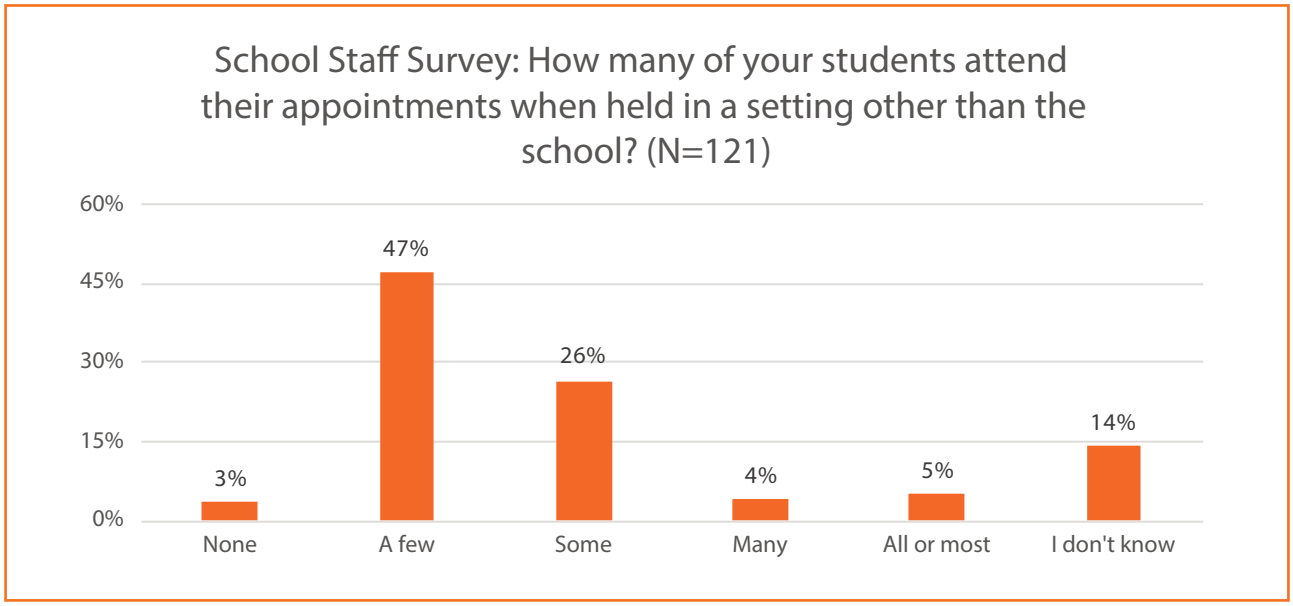
Children who participated in the research mainly identified benefits of school-based services for parents and teachers rather than the children themselves. However, they emphasised that children would already know staff delivering services in school and that it would *'be handy if you have mental issues to have people here that you could go to when you need to'* (Child Focus Group 9 SP5).

Parents recognised a range of benefits for their children including *'being more comfortable in their own surroundings'* (Parent 1), more timely access to services and missing less class time as evident in the following quote: '[School is] *often their safe place. It wouldn't be this daunting new building they're going in to. Timewise you're not taking a child out of school – they're going straight back in to their classroom*' (Parent 9).

Another parent indicated that children would be less likely to '*have the meltdowns that happen with breaking the routine*' (Parent 2) at clinic-based appointments.

School staff survey respondents were asked how many of their students attend appointments in a setting other than the school. **Chart 35** shows that the majority (47%) believe that only a few children attend appointments when held in a setting other than school. A further 26% indicated that some attend, followed by 14% who said they did not know. Only 5% indicated that All or Most attend their appointments delivered outside of school, followed by Many at 4% and None at 3%.

Chart 35 Students attending appointments in setting other than school



Staff focus group participants and principals also identified early and timely interventions when needs arise as a benefit rather than children having to go on lengthy wait lists for assessments and then again for services. Such timely intervention would prevent escalation of issues, which can have serious long-term ramifications and costs for children, for services and society:

> *'They're not able to fulfil their potential, and then that falls back on our health service. Unfortunately, it can often fall back on our Justice System. It can fall back on so many different areas. We wouldn't solve this … but we could certainly help towards resolving in that these issues, if they were dealt with at a young age. It just it really frustrates me. The new courthouse was built for 16 million, if we had a fraction of that here, I believe that we could stop putting a fraction of the people through that'* (Principal 1).

School staff also highlighted that that services would be more much more accessible for children and parents onsite in school as children could be collected at the class door and appointments would be attended on a more consistent basis. It would also reduce children's anxiety about leaving school to attend appointments in unfamiliar environments. Additionally, less school time would be missed. Further efficiencies would also be created where a student is not present in school on a given day and cannot attend an appointment as the space can be offered to another student.

Access to appointments onsite in the *'comfortable'* school environment ensures consistency of service provision for children and supports them to build relationships with multidisciplinary professionals so that they can '*open up*' as evident below:

> *'The children who need those kinds of services, they don't really open up to you on the first day.*

> *You know that kind of the way that they'd be more open and more comfortable with them coming to the school rather than the child being brought to this, you know, outside service every now and again. They're very comfortable at school'* (Principal 7).

School staff indicated that all children benefit when services are provided on site because currently, the focus is on children with extreme behaviours or severe needs, and other children with needs tend to go under the radar and their needs are not addressed. Onsite dedicated support would prevent children falling through the cracks and also facilitate identification by multidisciplinary professionals of children's needs that staff may not spot as illustrated in the following: *'It's a different set of skills to be observed, they've noticed one or two children with OT needs that we had never noticed with OT needs'* (Principal 11). The benefits would also extend to the learning environment as children would be better regulated and supported emotionally and therefore have greater capacity to learn and experience greater success in mainstream classes. Currently, a lot of time in class is spent focusing on children's emotional wellbeing which impacts on the teaching environment. Having dedicated therapeutic support onsite would help children to distinguish between the therapeutic and learning environment. For older children, regular therapeutic appointments in school would help them to focus more during class as they would know that they will get support.

School staff also highlighted the fact that children over eight years, who have timed out of some services, could still receive support. Overall, they felt onsite delivery of multiple services would comprise a more holistic approach to meeting children's needs and facilitate therapists to observe children in context in their natural day to day environment and thereby have a better understanding of children's needs. Post-primary schools feel that older children in particular feel stigma associated with attending services off site, which would be reduced if they could attend services onsite and not have to be signed out of school. One principal shared that due to stigma associated with mental health in some cases young people *'don't want to be seen to be going to an appointment in CAMHS. There is a resistance'* (Principal Interview).

Multidisciplinary professionals felt that schools were a '*natural and safe'* setting to work with children. Interventions can take place with as little disruption to the child as possible. It facilitates natural and easy communication with parents and teachers for the benefit of the child. The presence of the Creative Arts Therapist on the premises adds a degree of normality to attending therapy sessions and children are not as self-conscious about asking for or receiving support.

Those multidisciplinary professionals who had experience of working onsite in schools felt it was working well as highlighted below:

> *'Much of my work is in this setting at the moment and it works well…when you have a suitable timetable that supports children, with their breaks and extracurricular activities factored in…it makes the day much more simple to manage. The workload generally consists of up to 5 clients in a school day'* (Multidisciplinary Survey Response).

Benefit for parents

Children identified the financial constraints that multidisciplinary appointments outside of the school setting place on parents and not having to worry about transport was cited as an important benefit as evident in the keen understanding displayed by one child:

> *'Not all parents or guardians have the money to be getting buses and not everyone drives'* (Child Focus Group 2 SP2).

Principals also reported that extra support provided by the school incurs less cost for low-income families. Parents indicated that school-based services would be a lot more accessible for families and the informal nature of schools would make them more confident attending appointments. Parents shared that it would be very helpful for those who are working as they wouldn't have to leave work for extended periods of time: '*Some places don't even have a bus route out to them. It would be a lot easier for a parent to come and sit with their child in the school and the child* [is] *in their own comfort in the school*' (Parent 1). School staff also relayed that onsite provision is less stressful for parents, that there is an ease of access to services as transport is less likely to be required and parents do not have to cancel appointment for childcare reasons.

Consistent across all other stakeholder accounts was the belief that parents/carers have pre-existing positive relationships with schools and staff which in turn leads to trust in multidisciplinary professionals who deliver services onsite. In simple terms, school staff felt that while onsite delivery of services may be '*one less thing*' for a parent/carer to do, they emphasised that parents still need to part of process and present for intake, review and closing sessions. Principals reported that parents are more familiar with the school environment, have more trust and confidence in working within the school system as opposed to working with external agencies and felt schools were the '*obvious place*' for services to be delivered to children. One principal stated: *'I suppose they trust the school. And they know their kids are safe in school and I think it makes it easier to engage. And they have that relationship with the school*' (Principal 8).

Further, staff focus group participants indicated that onsite delivery in schools supports parents to build relationships with multidisciplinary professionals which in turn supports trust and better communication between parents and the service providers. Multidisciplinary professionals echoed this in survey responses indicating that time efficiencies are created when working onsite in schools as school staff usually have good relationships with parents which leads to '*faster and easier communication*'. School staff felt that once parents build relationships with multidisciplinary professionals onsite in schools, they might be more willing to travel to other parts of the city if required. This confidence in services is also greater if parents are introduced by someone they trust to multidisciplinary professionals e.g., the HSCL, because they already have relationships built with school staff.

School staff that had experience of multidisciplinary support onsite observed changes in parental perspectives on multidisciplinary support based on positive experiences in schools and building of

relationships with multidisciplinary professionals. Staff in one school indicated that parents now saw greater value in therapeutic support e.g., play therapy, and are requesting it for children rather than the school '*begging*' them to avail of the service.

Benefits for school staff

Participants clearly identified a number of benefits for staff from onsite multidisciplinary support including opportunities for consultation, guidance, collaboration, learning and receiving support from multidisciplinary professionals about how best to meet children's needs.

For teachers, children indicated it would help *'get the stress off the teacher's back'* (Child Focus Group 2 SP3), give more teaching time in class and develop greater understanding of students. Parents acknowledged the capacity-building potential of school-based services while identifying that teachers would be freed up to focus on teaching rather than '*having to act as psychologists, everything all rolled in one*' (Parent 4). They also acknowledged that school staff would be able to liaise with therapists without having to wait long periods of time for calls to be returned, as is the case with the current clinic-based system. One parent noted that therapists would be able to support a range of children at a time by observing behaviours incidentally during class visits.

School staff indicated they would feel less anxious, frustrated and powerless about whether they are doing the right thing to meet children's needs. They stressed that they are not trained in the areas of multidisciplinary support and are genuinely concerned about doing more harm than good by making '*shots in the dark'* to support children. They relayed the significant difficulty they have meeting the high level of need children in their classrooms have with one survey respondent stating: '*As a teacher, it can be difficult to fulfil your role while also trying to complete services that are beyond your qualifications'* (Staff Survey Respondent).

School staff also indicated that an onsite multidisciplinary team would facilitate direct communication with multidisciplinary professionals, reduce the significant amount of time spent 'chasing' information and referrals and provide expert advice and support children's development in a far more holistic manner and that *'joined up thinking'* would ensure better support for children. Both school staff and principals highlighted the learning that takes place from interaction with multidisciplinary professionals such as ideas and programmes which they could implement daily. This interaction was described as *'unseen professional development'* (Principal 5) for staff through observation of multidisciplinary professionals working with children. For example, teachers are '*getting to observe and watch a speech and language therapist in action and you know getting to see you know how to help the children. So, the SLT models, they observe, and they do the very same thing when the speech language service isn't here* (Principal 10).

Staff also felt that they would get support and would feel a '*sense of community'* from collaborating with multidisciplinary professionals in responding to needs of students. One survey respondent indicated that '*teachers could work in tandem with the specialists for the good of the children* (Staff Survey Respondent).

Teachers would also have a greater insight into children and what is going on for them as not all parents inform schools about whether children have been seen by specialists or services or not.

Overall, school staff felt the availability of services onsite would have a positive impact on behaviour in the school resulting in a calmer environment that positively impacts on teaching and learning and supports the children to achieve socially, emotionally and academically.

Benefits for multidisciplinary professionals and service delivery

Across participants groups, multiple benefits of onsite delivery of services were identified for multidisciplinary professionals and service delivery.

Parents could clearly see how school-based services may benefit service providers by taking the pressure off therapists, reducing wait lists, fewer cancelled appointments and very few no-shows. Parents also indicated that therapists would gain a more holistic impression of children by seeing them in the school environment. Principals echoed this as multidisciplinary professionals would see the child '*in their own normal environments…they can see the child more relaxed and maybe more realistic*' (Principal 6) and get *'a bigger picture'* of the child through direct communication with school staff. Principals felt that a one-off observation doesn't give service providers and an insight in '*what's going on for a child every day*' (Principal 7).

School staff also reported that multidisciplinary professionals could communicate directly with teachers and SNAs who would be putting recommendations into practice. Sometimes this information can be difficult for a parent to pass on to schools. Staff felt that the multidisciplinary professionals could *'work hand in hand with the teachers and SNAs on a more consistent level to help the children'* (Staff Survey Respondent). Service providers also acknowledged the instrumental role teachers play in supporting the therapy process, enhancing the relationship between psychotherapists and educators and leading to a network of trust and cooperation. This was cited as contributing to consistent attendance rates of around 85% in one setting.

Principals, school staff and multidisciplinary professionals indicated that one of the main benefits of onsite delivery would be a massive reduction in the number of missed appointments or Did Not Attends (DNAs) that are encountered in other facilities because of the flexibility and adaptability of scheduling in schools versus the clinic setting. Feedback in the previous section revealed that the majority of multidisciplinary professionals reported 81-100% attendance at school-based appointments. This was echoed by a multidisciplinary professional in the focus groups:

> *'Attendance records at school are phenomenal - 90%+ attendance every month* [at school-based appointments] *and not so much with in-house services'* (Multidisciplinary Focus Group 1 SP3).

Principal accounts also support this indicating that when services are provided in schools the '*attendance rates have been phenomenal*' (Principal Interview) with a minimal number of appointments missed and this far exceeded the level of attendance in clinical settings. This is partly due to high attendance at school and because school-based delivery allows for flexibility in relation to absenteeism. If a child who has a scheduled appointment is out, there is capacity for another child to avail of the appointment as evident in the following principal quote:

> '*Because the kids are here. Maybe eight kids that need speech and language on a day, if one of those kids is out, we still have seven more. So, the appointment isn't missed*' (Principal Interview).

School staff indicated that onsite support facilitates ease of referrals as multidisciplinary professionals '*already had links with agencies*' so their referrals '*are having much more weight than a teacher referral*' and hence appear to be '*getting fast tracked*' within the system which is to the benefit of children. Providing services on site in schools was highlighted as being more cost effective and efficient due to greater uptake of appointments and because there are no overheads e.g., rent, light and heat, to be considered, as illustrated in the principal quote below:

> '*Even from a cost point of view. It's costing you more to be renting an office or electricity utilities and somebody you're paying €60.00 an hour to meet these kids who don't show up...They're all in the school and we can get the parents to come into the school far easier than getting them to bring the child to a clinic somewhere in town at 2 o'clock in the afternoon*' (Principal 3).

Principals also relayed that students in Allied Health areas, such as those from UL involved in the HAPPEE Project, are learning about the benefits of working in schools, how '*effective*' it can be and how it '*maximises resources*' to the benefit of children.

For schools with a large range of multidisciplinary services already being provided on site in schools they can clearly see the benefits to children and families.

> '*We have currently 109 children accessing support …with 56 more on the waiting list…It's a shift away from the biomedical model where it's a narrative approach. We're looking to understand people's stories, just understanding their responses to trauma and various things that happen in their life. So, it's like I think that's fantastic …and everybody in the school is grounded in putting that framework in place*' (Principal Interview).

Challenges of onsite service delivery in schools

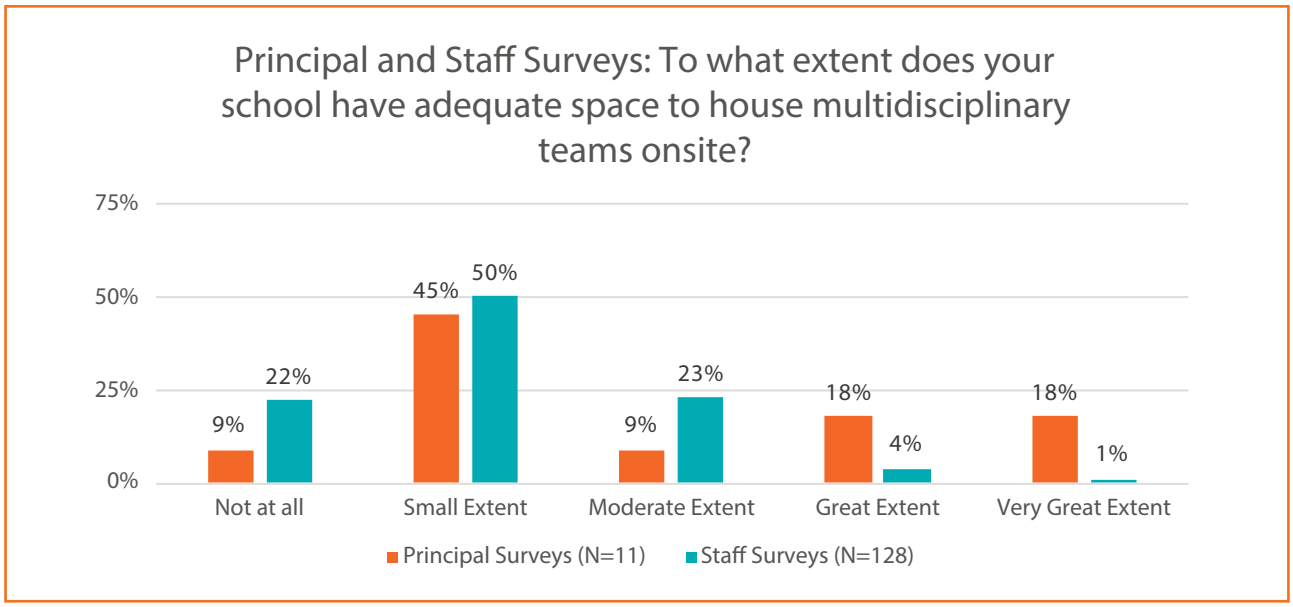
Whilst the majority of adult research participants were overwhelming in favour of onsite delivery of services in school, some challenges were identified including the additional workload for schools.

However, most felt the additional workload would be offset by the benefits which would reduce workload in other areas.

Principals acknowledged there is a lot of moving parts involved in onsite delivery which '*needs a huge amount of flexibility and adaptability and space in schools*' (Principal 11). They felt '*collaboration is the key to success*' but cautioned that not all staff members might be on board. Space and timetabling emerged as the main barriers to providing additional services.

Principals reported mixed capacity to house multidisciplinary teams onsite in their school with 45% indicating they had adequate space to a 'Small Extent', followed equally by 'Great extent' (18%) and 'Very Great Extent' (18%). A further 9% said they could do so to a 'Moderate Extent' and 9% felt they could not house onsite multidisciplinary support at all. School staff had less confidence than principals that their schools had adequate space to accommodate additional services as less than 1% of survey respondents (N=128) felt they had adequate space to house multidisciplinary teams onsite in schools to a 'Very Great Extent'. As evident in **Chart 36**, only 4% said they did to a 'Great Extent', 23% to a 'Moderate Extent' and 50% to a 'Small Extent'. The remaining 22% said they did 'Not at All' have adequate space to host services onsite.

Chart 36 Extent to which schools have adequate space for onsite multidisciplinary support



Similar to other stakeholders' space was the challenge most frequently cited by school staff focus group participants to onsite provision, however they generally indicated they would find a way to overcome this barrier. Indeed, a number of schools have identified solutions including sharing the use of spaces, partitioning of rooms and simply '*allocating every corner you could be using the stage we could, you know, you'll just find a corner*' (Principal 6). One principal suggested having a '*hub*' in the school where clinicians would have their own resources available and could see children '*on a daily basis*' (Principal 1). This would

support delivery of such services onsite '*on a cost neutral basis*'. Schools that do not have space felt they could share facilities between neighbouring schools. Some observed that having a multidisciplinary team onsite in each school, particularly smaller schools, may not be feasible and clustering of schools may help.

Lack of consistency in service delivery and subsequent impact on programme delivery was cited as a significant issue by school staff focus group participants. When multidisciplinary professionals from services go on leave, they are not replaced or there is '*chopping and changing*' of staff. There have also been embargos on recruitment and difficulties recruiting multidisciplinary therapists with shortages in some areas.

Concerns were also raised about '*stop-gap*' support and multidisciplinary professionals giving work to school staff to do or sending the teacher resources to use with a child rather than implementing interventions for children. Short-term interventions for children were viewed as less effective and desire expressed for long term interventions e.g., working with a child in a structured way for the school year. School staff emphasised that some initiatives or pilots currently being delivered in participating schools are highly dependent on the goodwill and volunteering of professionals.

A small number of staff felt that multidisciplinary support should be offered in the local primary health care centre rather than onsite in schools.

One principal felt that on site provision doesn't necessarily suit all children as some children prefer to attend services off site and be *'discreet about it'*. Challenges were highlighted by school staff where students may have to return to class after a therapeutic session related to mental health or where they may have discussed a distressing topic. In this instance, students may need time and space before returning to class. Half the children who participated in the research highlighted challenges to onsite services including lack of space and privacy. There is a real concern amongst some children that others would be more aware of the services they are accessing if they took place in school as illustrated in the following quote: *'I'd rather go out for appointments instead of being crowded in the school and people are in your business in school and a doctor's room is private'* (Child Focus Group 5 SP1). Another child stated: '*It's embarrassing when she* [the therapist] *looks through our classroom door*' (Child Focus Group 10 SP1). During the member check process with school staff, a further issue raised was that there can be negative associations with spaces in school where therapeutic services are delivered, with children referring to a dedicated room in one school as *'the sad room'.*

Other than lack of space, only three parents could identify any challenges associated with school-based practice. All other parents thought that school-based practice was a '*no-brainer*' and definitely the way forward. One parent's greatest concern was that the current school-based services her children avail of would be stopped due to lack of funds.

Challenges of onsite service provision for multidisciplinary professionals

Multidisciplinary professionals highlighted a range of challenges and considerations for school-based services to be successful. Similar to all other groups, the challenge of space was highlighted with multi-disciplinary professionals often feeling that they displace teachers and cause disruptions to other resources. The lack of dedicated space means service providers have *'to cart in and out stuff'* for each session and often the available rooms are too small to accommodate therapy groups effectively. Consistent and private space in schools to carry out therapy every week was identified as a concern and professionals felt it was key to ensuring that therapy is effective, as the illustrated in the following quote:

> *'Privacy is not always as it should be. The room that is used is quite often multifunctional and although the room is set aside for the day in which it is used as a therapy space, teachers and pupils etc. still forget this'* (Multidisciplinary Professional Survey Respondent).

Extracurricular activities can also disrupt therapy sessions in schools, particularly group sessions. Multidisciplinary professionals highlighted how busy schools are with *'lots of informal chats'* between clients. As such, '*it's difficult to have down time as a therapist*' (Multidisciplinary Professional Survey Respondent) which is important for therapists.

Before agreeing to work in a school some therapists highlighted the importance of working with staff and '*Educating staff on the vulnerability post therapy and helping staff understand that this is not like taking them* [children] *out for resource'* (Multidisciplinary Professional Survey Respondent). This is to ensure boundaries and confidentiality for their service. Some felt different stakeholders have varying ideas about how the service should work which can complicate implementation and high levels of emotional involvement can make it difficult to maintain boundaries and lead to emotional fatigue as expressed in:

> *'We're all so emotionally involved here, we're all so dedicated to here, that distance is difficult to maintain. I'm sure we can all be very tired at times. It's a level up in terms of emotional involvement'* (Multidisciplinary Focus Group 2 SP3).

Others highlighted the need to clearly explain the tiered intervention model to manage expectations and maximise effectiveness.

It is important to note however, that participants were willing to deal with these issues in order to continue with school-based therapy because they recognised the multiple benefits of this form of delivery as illustrated in the following quote:

> *'The child is in school for a significant amount of time in the week and being able to offer services during the school day poses positive experience - the child is receiving what they need, the family is being supported through the school, and the clinicians and school staff are able to work more closely together'* (Multidisciplinary Professional Survey Respondent).

Considerations for onsite delivery of services in schools identified by research participants

Greater provision of services to meet children's needs

Staff focus group participants and principal interviews identified many services and supports that are required to meet children's non-academic needs, enhance their readiness to learn and capacity to engage in education. These included consistent onsite speech and language therapy, occupational therapy, physiotherapy, psychologists to address emotional and behavioural concerns, therapeutic support for children e.g., play therapy, counselling, CAMHS. Lengthy wait lists for these services were highlighted by parents, school staff and principals. Some principals felt that some services work better in partnership than others, with some individuals and agencies '*working in isolation not knowing what the other person is doing*' (Principal 12). This type of service delivery model simply *'doesn't suit some of the families'* (Principal 9). Similarly, school staff reported '*a huge disconnect between a lot of the services and the school*' and that many services '*haven't recovered from COVID and the lockdowns and all the wait lists have built up and they are really struggling'* (Teacher School 2).

Many emphasised that school staff are not trained in the areas where children need support and therefore struggle to respond appropriately to children's needs in the absence of services and interventions for children as evident in the principal quote below:

> *'Multidisciplinary support onsite to me involves using the professional supports that are out there in the areas of speech and language therapy, physiotherapy, occupational therapy and dieticians. So, using their professional supports to be able to identify the certain needs of children…you know a child who was dysregulated. So, it has to be joined up thinking you know, and I suppose teachers are not experts in that field we're not trained in that area'* (Principal 6).

School staff and principals highlighted the need for a greater number of assessments from NEPS as well as wrap around health supports e.g., doctors, public health nurses, dentists. Additionally, the need for family support services, youth clubs, sports clubs, greater resourcing in the area and greater connections with the community were emphasised. Finally, the need for baseline data and research and evaluation of onsite delivery services in schools was also highlighted.

Multidisciplinary professionals understanding of the school environment and context

Multidisciplinary professional research participants identified a number of key considerations for the implementation of a successful and effective school-based model of service delivery including their own need to better understand the school environment**.** They felt they need to familiarise themselves with how schools operate and adjust their practices accordingly, balancing their methods with the school's needs. They also emphasised that they must be mindful of practical details, such as whether parents can complete forms, and understand expectations as external contractors.

Multidisciplinary professional research participants highlighted that not everyone is suited for school-based service roles; the position requires specific qualities and adaptability. Essential requirements identified for multidisciplinary professionals to work in schools and provide a relevant support include experience, accreditation, supervision and knowledge of the community context. As one participant indicated:

> *'Clinic-based practice is very different to in the school, so you have to be able to see it that way. I think you have to have a certain amount of experience to be able to work in a school – not just experience in your field but life experience. There's a lot going on* [in schools] *that you have to be mindful of'* (Multidisciplinary Focus Group 1 SP2).

This group of participants emphasised the need to establish strong, informal relationships and create a cohesive team to be successful. Mutual support and connection are key to effective collaboration. They also highlighted that multidisciplinary professionals must be adaptable and flexible to meet the needs of the school environment. Being present at school events and engaging with the community fosters positive relationships and makes multidisciplinary collaboration more effective. Finally, they highlighted that building relationships and establishing trust takes time, requiring patience and ongoing effort.

Sustainable funding for onsite services

Currently, schools are fundraising and applying for grants or donations to resource additional services for children. This is *'constant',* challenging for schools, and hugely time consuming for principals, but they know early intervention crucial: '*So, we've had to fundraise to do it or apply to charities, which I spent a huge amount of time doing'* (Principal 3). Outside of services delivered by staff from statutory services or the HAPPEE project onsite, there are a variety of funding sources that school try to access to pay for onsite multidisciplinary services including private or philanthropic funding, grants from statutory agencies, charities and the community and voluntary sector. However, principals feel they are constantly *'plugging holes'* and trying to find money to support children in crisis:

> *'In the last two days I had two children that are really struggling with mental health issues, and I need them to go to somebody. So, I will find that money, they need to go to see someone. That's all you can do. You're just trying to plug holes'* (Principal 1).

Smaller schools in particular struggle to source the additional funding required for services whereas others have built up a '*good network'* of philanthropic donors who they rely on to fund assessments and additional services annually:

> *'I'm applying for funding spending all my time outside of school, applying for funding, and like I'm applying for funding for random things… I have teachers and SNAs in school here that I'm paying for privately. Because we're so chronically short staffed, we're having to pay for them privately'* (Principal Interview).

> *'Every year you come back to the well trying to reinvent the wheel so it is not very sustainable no, which is terrible because we can see the benefit'* (Principal 6).

Some schools have found creative ways to fund multidisciplinary support, using the teaching allocation to provide services like psychology, music therapy, and art therapy:

> *'We have used our teaching allocation to get a psychologist in OK yeah. I don't know if it is the best use of hours but I'm doing it. So, it's teaching hours being used, going to a psychologist who comes in here to work with groups on a Monday, Tuesday because we can't get that from the Department, and we need that'* (Principal Interview).

In the absence of sufficient external support, some schools have invested in upskilling their own staff. For example, one school funded a teacher to train as a play therapist to provide in-house support:

> *'The board of management funded a teacher to train to be a play therapist... so they're now taking six children every Thursday'* (Principal 10).

For these reasons, providing multidisciplinary support onsite was cited as '*another thing that schools are taking on*' (Principal 9).

While very welcome by schools because of the level of unmet needs, short-term pilot projects to deliver services in schools were described as *'myopic'* and the need for long-term, continuous funding was identified as illustrated below:

> *'These pilot projects start up where they get a bit of funding, they identify bit of a need and the put together this programme for a certain length of time and it's all myopic thinking. There's no, where are we going with this? Where's the continuity? Where is two and three- and four-years' time'* (Principal 3).

Overall, principals expressed frustration that greater onsite service delivery wasn't happening in their school particularly as it requires *'minimal flexibility'* (Principal 1). Principals indicated real progress could be made for children if they had the resources, with one principal sharing *'I would be very confident in two or three years' time if I had that multidisciplinary team, if I just was able to flood the school with the supports and services and meet the chronic needs, we could start turning this thing around and I know we could because it's worked in other places'* (Principal 3).

They also felt there would be huge benefits to the public system if services were provided on site as it would '*release the strain there*' (Principal 6) and reduce wait lists.

Developing relationships with and supporting parents

Both principals and school staff emphasised the importance of home and school communication in building trust and relationships to facilitate children with additional and more complex needs to successfully access support through intervention within school and to access support from external services.

Schools detailed a wide variety of support they offer for parents to assist them with the referral process:

> *'The class teachers will assist the parents with referral forms and information gathering. Prior to GDPR, we could be notified of appointment times and dates, and we used to remind parents. The HSCL would visit homes and remind parents. On occasions we might have collected and driven children and their parent(s) to appointments'* (Principal Survey Respondent).

To support parents with literacy and English language needs HSCLs help parents to complete referral forms. With parental consent, HSCLs/schools request services to copy them on letters to parents about appointments so they can help with not only understanding of the forms but also remind parents of their scheduled appointments. Staff focus group participants highlighted numerous ways in which schools support parents to bring children to appointments. Only staff in one focus group, neither of whom was the HSCL, indicated that they had not taken parents to appointments themselves. School staff also spoke of SCP staff taking children and parents to appointments or providing other means of transport. Moreover, some HSCLs attend appointments with parents if they request them to do so. Schools have also hosted appointments onsite to ensure that children are seen by services and have advocated on behalf of parents with services.

The support that parents receive in the referral process can often take several weeks with a considerable amount of work involved:

> *'It takes several weeks to support families to start the journey for external supports, this involves meetings, sharing information, helping fill out referral forms, writing letters to these services on behalf of families or representing the school's experiences of working with the child'* (Staff Survey Respondent).

Principals highlighted the challenges to developing relationships with parents that can be experienced with particular reference to accessing external support for children. In some instances, parents can be the source of difficulties that a child or young person is experiencing or there may be language or cultural barriers. In such instances, schools *'need to be very tactful'* (Principal 3). On occasion, school staff may have to work with social workers before a referral is made for a child to particular services. Principals also relayed the challenge in trying to communicate the process of lengthy wait lists to parents or how services prioritise children for support.

A holistic and integrated model of support

A holistic and integrated multidisciplinary model, focused on a child's strengths and needs, was identified as the ideal model of support. This approach involves collaboration between teachers, psychologists, speech and language therapists, occupational therapists, and other specialists to create a unified plan for each child:

> *'The World Health Organisation would say best outcomes for children would be when a multi-disciplinary team sits together around a child and looks and focuses on their strengths and needs'* (Principal 2).

Principals envision schools becoming '*one-stop shops*' where various services, including medical, mental health, social welfare, and financial support, could be accessed in a familiar, comfortable setting:

> *'I would love to have a one stop shop for health, for example, that you know that the doctor would be on site once a month that they could deal with their needs. Housing could have, you know, would come on some kind of the basis that maybe someone from MABs, you know money management that maybe social welfare would come because again it's the same thing that this becomes an all-encompassing facility where people feel comfortable, and they can access everything in one. Where they already feel safe'* (Principal 1).

Principals suggested that neighbouring schools could collaborate to share resources and facilities for multi-disciplinary services, ensuring that children from multiple schools could benefit from onsite support:

> *'I would love the idea of schools coming together... if someone had extra capacity in terms of space, we would be able to all access that building'* (Principal 4).

There are a range of areas principals would prioritise for onsite support including speech and language therapy, occupation therapy, psychology and physiotherapy. Some schools are currently receiving no actual onsite service delivery with only observations taking place.

One principal highlighted the City Connects model, implemented in Dublin's North East Inner City, as an example of effective, coordinated support. This model involves a database tracking each child's needs and progress, with multidisciplinary teams working together to address them.

The HAPPEE Project, which facilitates onsite multidisciplinary services through student placements was also highlighted by principals who outlined the benefits for children and schools:

> *'We're picking up their expertise as well, lot of different ideas that we wouldn't have'* (Principal 11).

Others felt full time access to an educational psychologist is a priority for schools: '*We would absolutely need to have access to an educational psychologist, right? As opposed to two assessments in the year, which is what we get, which is meant to be the enhanced service that DEIS schools get*' (Principal 12).

Overall schools expressed a strong desire for more consistent, structured, and holistic service delivery to better address the complex needs of students and their families. The majority of principals (82%) and staff (63%) surveyed also indicated that they would like to provide additional services for parents onsite as part of a more holistic and integrated approach to service provision.

Section 6

Key Learning, Recommendations and Conclusion

Section 6 - Key Learning, Recommendations and Conclusion

This research set out to establish the level of need for multidisciplinary support onsite in Oscailt schools, the types and quantity of support needed and provide guidance on how multidisciplinary support might be delivered.

It is evident that the current systems of multidisciplinary support, both through the statutory system and community and voluntary sector, while very welcome and necessary, are clearly not meeting the needs of children and young people in Oscailt schools and Regeneration communities in Limerick and therefore are not fit for purpose. Additionally, the research shows that these students have a range of needs in other areas that must be addressed so that they can reach their potential highlighting the requirement for an integrated system of support in Oscailt schools.

The following sections delineate the key learning from this research and key considerations, implications and recommendations to meet the multidisciplinary support and holistic needs of students in Oscailt schools and Regeneration communities.

Key learning from the research

The current systems of support are under resourced, inefficient and not meeting the significant level of need for multidisciplinary support in Oscailt schools and Regeneration communities

The current systems of multidisciplinary support, both statutory and community and voluntary, are not meeting the needs of students in Oscailt schools and Regeneration communities. The system of support is not fit for purpose due to endemic, system level barriers such as lack of resources, lack of cohesion, recruitment challenges and lack of flexibility to meet the needs of children and parents living in areas of high socio-economic deprivation such as the Regeneration communities in Limerick. Only children with the highest level of needs are likely to even be considered for support thus many children with significant needs are not being considered for support due to pressure on multidisciplinary resources. As a result, the responsibility and burden of meeting students' multidisciplinary and other support needs is left to the Oscailt schools, highlighting the stark inefficiency of statutory services in both the education and health sectors.

The complexity and variety of needs detailed throughout the findings illuminates the challenges for students, parents and staff associated with teaching and learning in the DEIS school context. Priority needs at the individual level, related to family context, attendance and other areas such as community context were identified by principals and school staff in surveys. It is evident from across the findings that there is a significant level of need for multidisciplinary and other supports for students in the Oscailt schools with student needs in the following areas being identified as paramount by school staff and principals: emotional and behavioural support, support for separation/divorce/single-parent family,

community context, speech and language and social skills. Principal and school staff respondents indicated in the surveys, interviews and focus groups that they did not have adequate resources in their school to respond to the variety and complexity of needs. The main services identified by participants to respond to student needs include: Creative Therapies, Family Services, CAMHS and NEPS.

Oscailt schools are a significant source of support for students and parents

The extensive level of care and support that Oscailt schools currently provide daily for students and their families in relation to non-academic needs was apparent from research participants' accounts. This ranged from supporting completion of referral forms and attendance at appointments, to offering extracurricular activity, and providing emotional and practical support for families coping with trauma, instability and crisis, to responding to the basic nutritional and clothing needs of some children. The positive relationships schools have built with children, young people and parents, particularly through the HSCL and principal role, facilitates them to provide these supports. However, this support is not sufficient to meet the extraordinary level of need encountered in the participating schools for a variety of reasons which are related to societal inequity and the socio-economic context of the schools as detailed in the Section Two. Responding to such high levels of need for support in the absence of adequate resources places substantial pressure and an emotional toll on both school staff and multidisciplinary professionals. It also involves a considerable level of school resources e.g., staff time spent providing or organising support or raising funds for supports, which detracts from school staff time spent on the core business of teaching and learning. This is not a sustainable model of service delivery.

The findings show that most principals (91%) and staff (69%) indicated that students have access to multidisciplinary professionals onsite in a therapeutic/consultative context, from the statutory and non-statutory services, with Creative Therapists and Educational Psychologists cited as most frequently available onsite in schools.

However, the level of onsite multidisciplinary support in individual schools is quite varied across the 13 schools that participated in the research. In some instances, it is dependent on whether staff from local statutory services e.g., HSE Primary Care – Occupational Therapy, Physiotherapy, Speech and Language Therapy, deliver such services in schools. Some principals indicated in the interviews that multidisciplinary professionals from statutory agencies have only visited the school to conduct an observation of a student. Some schools have minimal levels of multidisciplinary support onsite, and others are at a more advanced stage with greater resources, capacity and flexibility to respond to the needs of both children and parents. Schools indicated that they put significant efforts into fundraising to provide multidisciplinary support for children in areas such as Counselling, Creative Therapies, Educational Psychology Assessments, and Speech and Language Therapy.

Collaborative initiatives that provide multidisciplinary support onsite in Oscailt schools such as 'The Sky is the Limit' Corpus Christi Family Centre and the HAPPEE project were reported as having positive impacts for children. HAPPEE was found to provide an accessible and supportive setting for therapeutic support

for children in the familiar school environment with 98% attendance at school-based appointments (Hickey, 2025a). Similarly, 'The Sky is the Limit' removes a variety of barriers to children and parents accessing a range of services. Strong, trust-based relationships between children, staff, parents/carers and partner agencies increases the likelihood of families seeking and receiving the help they need (Hickey, 2025b). However, both these initiatives are dependent on the ongoing fundraising efforts of key staff. Serious concerns were raised about the short-term nature of much of the onsite multidisciplinary interventions provided by both statutory and non-statutory organisations and the need for long-term continuous provision was stressed to meet long-term needs.

While schools were generally satisfied with the NEPS Educational Psychologist assigned to them and the support they provide, inadequacy regarding the number of assessments per school was highlighted with 2-3 assessments per school considered to be far below that which is required. That NEPS does not maintain a waiting list obfuscates discernment of the level of need locally. Issues related to cover for statutory leave of Educational Psychologists were raised and one school relayed not having an Educational Psychologist assigned to their school for an extended period.

Support for children and young people in crisis was identified as a gap with reference to mental health and sexual assault. Afterschool support and facilities for extracurricular activity in the communities in which Oscailt schools are based were also identified as a gap.

Referral pathways are complicated and there are lengthy wait lists

Research participant accounts depicted a complicated and confusing referral process and pathways for multidisciplinary support, particularly clinic-based support, despite the concise diagram, **Figure 4**, presented in Section Four, and stated aims of the 'Progressing Disability Services' document. Systemic issues such as a chronic lack of resources, lack of cohesion across service pathways such as the CDNT and Primary Care, lack of cover for staff on statutory leave, recruitment challenges and the lingering impact of COVID were highlighted.

For parents in Oscailt schools, the system is particularly confusing and difficult to navigate and the literacy levels required to complete forms can be a significant barrier, as can the level of detail often required for referrals. For principals and school staff, chronic under resourcing of multidisciplinary services and limited availability of supports such as Creative Therapies creates pressure to identify and refer the children whom they think will get the most benefit from the service or who have the greatest likelihood of parents engaging with the process. This means that there are many children who have significant needs that are not even being considered for support and that children whose needs are less visible to school staff completely fall under the radar until they are in crisis. Not being able to refer directly to CAMHS was a particular concern identified by principals in addition to general lack of communication by the agency with schools about children and young people.

Lengthy wait lists for initial assessments and resulting delay in the delivery of statutory services were

stressed by all adult research participants. Depending on the service, wait lists of up to two years for initial assessments and up to four years for service delivery were relayed. Both parents and school staff indicated that they spend a considerable amount of time following up on referrals. While the HAPPEE initiative is helping in the six participating schools, the short-term nature of the interventions in the face of the scale of need is a significant challenge. Similarly, short-term 'stop-gap' interventions by statutory services were also deemed insufficient and mere 'tick the box' exercises given the scale of needs presenting in schools. Children being removed from wait lists for services because of missed appointments or based on a discussion with a teacher versus an assessment of the child by a multidisciplinary professional were cited as significant challenges. The costs associated with private services were identified by all adult groups as prohibitive for most parents in Oscailt schools. Most schools spend a considerable amount of time applying to various sources for funding to deliver multidisciplinary services onsite in schools.

Oscailt schools are important sites for delivery of multidisciplinary services that help to overcome barriers associated with clinic-based services

All principals, the majority of school staff (97%), multidisciplinary professionals (90%) and parents (92%) involved in the research were in favour of school-based delivery of multidisciplinary services. Data from multidisciplinary professional surveys (see **Chart 33**) indicates that they have greater levels of attendance onsite in schools in comparison to clinic-based settings. Many barriers to attendance at appointments in clinic-based settings were identified including parental engagement, transport, childcare, parents at work, families' circumstances and parental lack of trust in statutory service providers. The main rationale cited for onsite delivery in schools was to overcome these barriers to parental engagement associated with clinic-based delivery, particularly lack of trust in services. Half of the students who participated had reservations however, sharing concerns related to privacy and the risk of other students being aware that they were seeing a multidisciplinary professional in the school.

The findings detail many benefits for children, parents, schools and multidisciplinary professionals of having multidisciplinary support delivered onsite in Oscailt schools, the most immediate being maximising resources, greater uptake of services due to high levels of student attendance at school and reduction of wait lists. Benefits for students included early and timely intervention, supporting children whose needs fall 'under the radar', missing less school time, less anxiety regarding unfamiliar environments and comfort in the 'safe space' of school. It was also cited as increasing parental engagement due to overcoming issues of cost and logistics and greater levels of trust in schools and thus, greater uptake of appointments. Other benefits included a less stressful teaching and learning environment due to greater regulation amongst students, more holistic intervention to meet students' needs and greater understanding amongst school staff and multidisciplinary professionals about students. Further, this type of delivery was felt to facilitate ease of communication between multidisciplinary professionals, parents and school staff, upskilling of school staff, and enhance collaboration between multidisciplinary professionals and school staff that contributes to a greater sense of wellbeing by reducing anxiety and frustration in relation to meeting students' needs.

Challenges associated with onsite multidisciplinary support in Oscailt schools

Delivery of onsite multidisciplinary support poses challenges such as maintaining boundaries between multidisciplinary professionals and school staff to protect student privacy, lack of appropriate space in schools for therapeutic interventions, disruption to the school environment and scheduling of appointments for multiple multidisciplinary professionals in busy school timetables. Additionally, students' own concerns about lack of privacy were palpable highlighting the need for a child and young person-centred approach that takes their wishes into consideration. Most adult research participants believed that these challenges could be overcome.

Key considerations for future delivery of onsite multidisciplinary support in Oscailt schools

Several key considerations for future delivery were detailed by research participants. These include the clear and urgent requirement for greater levels of service provision across a variety statutory and non-statutory services to meet the demands for services based on the needs of children and young people in Oscailt schools. Priority areas for support are identified in Section Four – Part One, and corresponding service delivery is required in the areas of Creative Therapies, Family Services, CAMHS and NEPS. Adequate and sustainable long-term funding is required for delivery of both clinic-based and school-based delivery of multidisciplinary services. The need for greater systemic coherency, 'joined up' thinking and flexibility between Oscailt schools and service providers to meet students' ongoing needs is evident and lack of willingness or capacity of some statutory services to work in partnership with schools and other agencies was cited as a key barrier. Greater support from service providers to develop relationships with parents in Oscailt schools to facilitate engagement with services and ensure children attend appointments was identified as a priority area. Strong desire was expressed for a structured, consistent, holistic and integrated model of multidisciplinary support for students in Oscailt schools involving collaboration between schools, service providers and multidisciplinary professionals. A system of integrated student support such as the City Connects model and Multidisciplinary Team in the NEIC, Dublin was identified as having positive impacts and significant potential for bringing systemic coherency to delivering student supports in Oscailt schools. In the absence of adequate multidisciplinary resources in schools, programmes such as 'The Sky is the Limit', and HAPPEE have provided valuable in-school multi-disciplinary supports in a number of DEIS schools in Limerick.

Implications and recommendations

Implications and recommendations for practice

A holistic, integrated child and young person-centred approach that operates from a human rights perspective and places their needs at the heart of service delivery

Children and young people must be put at the centre of systems of multidisciplinary support and doing so requires a shift in perspective from service providers about where and how multidisciplinary support is delivered. The Ombudsman for Children (2025) highlighted that to meet the needs of the most vulnerable children, including those with disabilities and from minority backgrounds, the new Inclusion

Framework for Health should focus on eliminating barriers to healthcare access for those groups. Placing children at the centre of systems of multidisciplinary support enables the most vulnerable children to access their right to education and healthcare. In contrast, the current system impedes vulnerable children from fully accessing their rights as they are service oriented with providers' interests at the locus of decisions about where and how multidisciplinary services are delivered. Provision of multidisciplinary support onsite in Oscailt schools helps to overcome many barriers to accessing these supports as schools generally experience good daily attendance, have built relationships of trust with children and families over many years and are a safe, welcoming space for children and parents/guardians. The findings from this research unmistakably indicate a high level of commitment to onsite multidisciplinary support in Oscailt schools because this mode of delivery removes the barriers inherent in clinic and statutory based services and ensures that the most vulnerable and marginalised children and young people have access to same. However, service delivery must be cognisant of the needs, wishes and concerns of children, young people and parents/guardians and clinic-based alternatives should be offered as appropriate.

The lack of integration, cohesion and flexibility between various parts of the multidisciplinary support systems was marked in these research findings and highlight the requirement for a cohesive and integrated response from a variety of sources in Limerick City, including schools and a variety of statutory, community and voluntary agencies. The referral systems and multidisciplinary support pathways must be reviewed with a view to providing a holistic, integrated and cohesive approach for children and young people in Oscailt schools based on their needs. This will require collaboration and partnership between statutory and community and voluntary sector multidisciplinary providers and professionals and Oscailt schools. The model of integrated student support in the NEIC, Dublin, in which a Multidisciplinary Team and City Connects were implemented in tandem, would help to bring systemic cohesion to area-based service delivery in Regeneration communities.

Greater resourcing for sustainable multidisciplinary support for students in Oscailt schools

Existing resources for multidisciplinary support are not meeting the demand in Oscailt schools and thus schools are compelled to fundraise for a host of multidisciplinary and other supports including Creative Therapies, Educational Psychology assessments and Speech and Language Therapy. Children and young people in Oscailt schools require and deserve greater levels of sustainable multidisciplinary support to fully access and benefit from their education, to maximise their potential and achievement and to improve their overall life opportunities and quality of life. A higher level of resourcing for multidisciplinary support for students in Oscailt schools and Regeneration communities is required. There are very promising models of multidisciplinary support already in some of the Oscailt schools such as 'The Sky is the Limit' and the HAPPEE initiative. However, these initiatives are dependent on ongoing fundraising and in some instances, voluntary contribution of key staff members. Furthermore, the short-term nature of some interventions prevents long-term progress for children and young people and sustainable, long-term funding is required. In addition to sustainable resources, the lack of appropriate and private space in schools for therapeutic support must be addressed and potential for sharing of space between clusters of schools should be examined.

Maximising parental engagement and increasing uptake of appointments

The findings detail the level of support that Oscailt schools provide for students and parents to encourage and facilitate engagement with multidisciplinary appointments in both the school and clinic-based setting. The current referral systems and pathways, which are confusing and require better alignment, include a number of systemic barriers as they often require a significant level of detail from parents/guardians and are not cognisant of literacy or English language needs of parents/guardians. HSCLs, SETs and principals are ideally placed to provide support for parents where schools are involved in the referral process. It is incumbent upon service providers funded by statutory agencies to consider ways to increase engagement and communication with parents and schools to ensure that children are attending appointments. These findings indicate that the hardest to reach parents lack trust in statutory services and children often feel uncomfortable in clinic-based settings. Adopting a Trauma Informed Services approach could help to mitigate these factors. However, given the higher levels of attendance at appointments in schools and engagement of parents, alternatives to clinic-based appointments, such as onsite delivery in schools, must also be endorsed and fully supported by statutory agencies to maximise valuable resources and increase the uptake of appointments by those who are most in need of same.

Other areas where support is required to meet the needs of children and young people in Oscailt schools

Findings indicate that Oscailt schools play a significant role in responding to the non-academic needs of students and their parents. Other areas where support needs were identified were family and community context needs. These encompass single-parent families and divorce/separation, homelessness and housing needs, addiction, mental health, domestic violence, families living in crisis and/or with trauma and violence and crime in the communities where students live. This underscores the need for an integrated system of support, such as City Connects which is currently being delivered in the NEIC, Dublin, to help identify the range of needs of all students in Oscailt schools and Regeneration communities to ensure that they are linked with a variety of in-school and community-based services.

Lack of safe places for children and young people in the local community was highlighted by school staff and principals in addition to a dearth of community-based afterschool and extracurricular activities and facilities. As detailed in Section One, the Oscailt network originally emerged from a Dormant Accounts funded initiative that aimed to maximise the use of schools by the wider community and this model should be considered as part of an overall response to children and young people's needs.

While the Oscailt schools offer many valuable supports for parents, there is scope to increase this support and offer onsite multidisciplinary support for parents in addition to their children. The insights from 'The Sky is the Limit' Corpus Christi Family Centre research report (Hickey 2025b) offer much food for thought.

Recommendations for practice

- As an immediate action, Limerick Regeneration Local Strategic Advisory and Monitoring Group should convene a Student Support Working Group involving Oscailt school principals, relevant statutory and community and voluntary multidisciplinary providers and other stakeholders as appropriate to review multidisciplinary support in Oscailt schools and Regeneration communities.
- The Student Support Working Group should conduct a collaborative review of referrals and multi-disciplinary pathways for students in Oscailt schools and Regeneration communities. This review should involve a detailed audit of the level of need for each multidisciplinary support service by school and community area and specification of resources required to meet those needs. The findings in this report provide a helpful starting point but there is a gap in the data on wait lists of children and young people from Limerick City and Regeneration communities for Primary Care in particular for both initial assessments and service provision.
- The Student Support Working Group should work in collaboration with the newly formed Health Equity Region Oversight group, under the auspices of the Director for Public Health, HSE and the Mayor. This group adopts a Public Health approach informed by the Marmot principles[22] to improving outcomes for children, young people and adults. It will commence with a preliminary focus on children and young people in CHN7[23] and 8 which correspond with the north, south and inner-city areas of Limerick City.
- Statutory and community and voluntary providers of multidisciplinary support in Oscailt schools and Regeneration communities should review existing wait lists, provision, and resources and identify both resource needs and potential services that could be delivered onsite in schools to maximise resources.
- The Student Support Working Group should develop a holistic framework and plan of action to implement multidisciplinary support for students from Oscailt schools and Regeneration communities that involves both onsite delivery in schools and clinic-based multidisciplinary support as appropriate. This framework and plan should include an audit of wait lists for existing multidisciplinary services, identify priority areas for support, address barriers in the referral process, and specify how the various statutory, community and voluntary agencies and schools will work together to meet the multidisciplinary needs of children and young people in Oscailt schools. The plan should also include a set of proposals to streamline access to service provision for children from Oscailt schools and Regeneration communities with multidisciplinary needs. Additionally, the Student Support Working Group should also consider how to address other needs i.e., community-based facilities for children and young people, afterschool and extracurricular activities, parent's multidisciplinary needs and overcoming cultural, linguistic and literacy barriers which are issues for many families.
- To ensure a cohesive and integrated response to the multiplex of needs of students identified in this report, an integrated system of student support should be implemented in Oscailt schools,

[22] The eight principles include: 1) Give every child the best start in life; 2) Enable all children, young people and adults to maximise their capabilities and have control over their lives; 3) Create fair employment and good work for all; 4) Ensure a healthy standard of living for all; 5) Create and develop healthy and sustainable community places; 6) Strengthen the role and impact of ill health prevention; 7) Tackle racism, discrimination and their outcomes; 8) Pursue environmental sustainability and health equity together.

[23] CHN=Community Health Network

such as, City Connects and the Multidisciplinary Team currently being implemented in the NEIC, Dublin. This will ensure that every single child in Oscailt schools will be reviewed annually, will have an individual plan put in place which matches them with available services to meet their needs, and that all students receive the right service at the right time. A system like City Connects builds a coherent network around the child which knits the community together and harnesses existing resources in the community to provide afterschool and out of school programmes to support children and families across the domains of social, emotional and behavioural needs, academics, health, family and transitions. Taking into account the significant level of children's needs in Oscailt schools, an integrated system of student supports would ensure that no child falls through the gap.

Implications and recommendations for policy

A cross Government, inter-departmental response is required to meet the needs of children and young people in Oscailt schools and Regeneration communities

Given the socioeconomic context of Limerick City and Regeneration communities outlined in Section Two and significant level of need for multidisciplinary support identified in this report, a cross Government, inter-departmental response is required. As such, this report will be of interest to the Child Policy and Well-being Programme Office, an inter-departmental working group in the Department of An Taoiseach. Limerick City clearly has significant levels of deprivation and unemployment in comparison to other cities and national averages. Regeneration communities also fare worse than other areas of the city and national averages regarding education and employment levels. Parts of the city have much higher levels of citizenship other than Irish in comparison to the county and national average. Taken together, these statistics and the research findings show that there is a significant level of need for resources and support for children in Oscailt schools and Regeneration communities.

Oscailt schools are well situated for implementation of a variety of initiatives and supports

The literature review section detailed several multidisciplinary initiatives and pilots being implemented by the Department of Education and other statutory agencies in other parts of the country including the Counselling for Primary Schools Pilot, Education Therapy Support Service being rolled out by the NCSE, and the Multidisciplinary Team in the NEIC, Dublin. It also outlined commitments in education, health, disability and child and young person mental health under the Programme for Government that are pertinent to DEIS schools and multidisciplinary support. These include a DEIS Plus programme, ensuring the National Therapy Service in Education allows children in SEN classes and mainstream to access essential therapies, reducing the wait list for an Assessment of Need, reform of the Disability Act (2005), review of the EPSEN Act (2004), training of more therapists in key areas and regulation of CAMHS.

Oscailt schools are also ideally placed to deliver other collaborative initiatives aimed at improving outcomes for students in DEIS schools such as the City Connects initiative. The long-established infra-structure of the Oscailt network has facilitated development of strong working relationships between schools and other key stakeholders in the local landscape. It also has a proven track record of responding

proactively to the challenges faced by DEIS schools and working in collaboration and partnership with key stakeholders to implement initiatives to support children, families and school staff.

NEPS Assessments

The research findings indicate that the allocation of NEPS assessments to Oscailt schools is not sufficient to meet demand and that schools make significant efforts to fundraise to support students whose parents cannot afford private Educational Psychology assessments. While recognising the system level issues in relation to training, staff shortages and recruitment in this area as outlined in Section One, given the educational profile of the Regeneration areas in the city as per **Table 9**, which shows much lower percentages of the adult population with primary, secondary and third level education, the level of NEPS support for these areas should be reviewed and enhanced. A review of the allocation of assessments to Oscailt schools in comparison to the level of need schools themselves have identified is an essential part of the recommended audit and review of services and framework for the development of a holistic, integrated and cohesive approach to multidisciplinary services.

CAMHS and mental health supports for children and young people

The actions identified by the Programme for Government in relation to CAMHS, which was a service identified in this research as having little interaction with schools, are welcome. Schools cannot refer to this service as children and young people must be referred by a GP and therefore communication between CAMHS and schools, with parent/guardian permission, needs to be reviewed. The findings from this research support other key actions outlined such as targeted supports for children with autism experiencing mental health challenges and a proposed new care model for HSE Primary Care Psychology to expedite services for young people with less complex issues.

Recommendations for policy

- A cross Government, inter-departmental response will be required to meet the multidisciplinary needs of children and young people in Oscailt schools and Regeneration areas. Support from government will be required to ensure that same happens. The Mayor of Limerick, as per his Mayoral Plan, can play an important leadership role in bringing political visibility to the urgent and significant need for resources for multidisciplinary support and for a cohesive and integrated response to meet the needs of students in Oscailt schools and Regeneration areas.
- The Department of Education and NCSE should include Oscailt schools in the expansion of pilot initiatives such as the Education Therapy Support Service. This will require collaboration between the NCSE and HSE in relation to multidisciplinary support needs and service delivery to avoid duplication of services.
- Oscailt schools should also be prioritised by the Department of Education for inclusion in the DEIS Plus programme and expansion of City Connects.
- The allocation of assessments by NEPS for Oscailt schools should be reviewed and enhanced to fully meet the needs of children and young people from Regeneration communities.
- The HSE should implement a Multidisciplinary Team onsite in Oscailt schools and Regeneration

communities in Limerick involving Speech and Language Therapy, Occupational Therapy, Physiotherapy and Clinical Psychology. This should be delivered in consultation and collaboration with schools and NEPS.

Implications and recommendations for research

Audit of wait lists for statutory multidisciplinary services

No information on wait lists for an Assessments of Need or HSE funded multidisciplinary services in Limerick City was provided for this report, despite numerous requests over the course of the research. Data was sourced from what was available for CHO3 in response to PQs posed by TDs. This constitutes a significant gap in the data that needs to be addressed to progress the key recommendations arising from the report.

Evaluation of implementation and outcomes for students

Implementation of any new initiatives to improve outcomes for children and young people in Oscailt schools and Regeneration areas, either in the area of multidisciplinary support or other areas, should be evaluated to identify what is working well and what could be improved for service delivery and to fully assess outcomes for children and young people.

Recommendations for research

- The HSE should provide full details of wait lists for Assessment of Need and HSE multidisciplinary services in Limerick City for children and young people in Oscailt schools and Regeneration communities.
- Future implementation of initiatives in multidisciplinary support and other areas delivered in Oscailt schools and Regeneration communities should be evaluated.

Conclusion

This research was undertaken in response to the Oscailt principals' concerns about the long-term impact of school and multidisciplinary service closures during COVID on the mental health and academic development of children and young people in Regeneration communities in Limerick City. Five years on from these shutdowns in March 2020, grave concerns persist, and this research reveals an urgent and significant need for support in a variety of multidisciplinary areas to improve the overall quality of life, mental health and wellbeing of students who attend the Oscailt schools. Systemic barriers, lack of resources and lengthy wait lists for initial assessments and services are not only preventing students in Oscailt schools and Regeneration communities from realising their rights in relation to education and healthcare, but they are also severely limiting their overall quality of life and life opportunities. This trajectory need not be inevitable and can be improved with a holistic and integrated child and young person-centred approach to multidisciplinary support that places their needs at the heart of service delivery. This requires an inter-departmental response with cross Government commitment to ensure that an integrated, cohesive and structured collaborative framework and plan to improve outcomes is put in place for students in Oscailt schools and Regeneration communities that considers multidisciplinary support needs as well as needs in other areas. Gaps identified in this research include supports for children in crisis, and afterschool and extracurricular facilities and activities. Long-term, sustainable funding is essential and greater allocation of resources is required from a variety of health and education services including NEPS and HSE Primary Care. Oscailt schools are well placed to implement a variety of collaborative initiatives and supports such as a Multidisciplinary Team, the School Inclusion Model and City Connects.

Essentially, children and young people in Oscailt schools and Regeneration communities, many of whose parents cannot afford private services, deserve better than to 'languish' for years on wait lists in 'dead services', while their parents struggle to navigate complex referral pathways and get struck off wait lists for non-attendance, and school staff are forced to fundraise and 'play God' deciding on how to allocate limited resources.

Appendix 1 - HP Deprivation Index Tables

Table 14 Electoral Divisions from which Oscailt schools enrol students and HP Index Score and Classification

Electoral Division	Population	HP Index Score	HP classification
Abbey C	670.00	-10.55	Disadvantaged
Abbey D	1,477.00	-20.38	Very disadvantaged
Ballinacurra B	1,353.00	-12.58	Disadvantaged
Ballynanty	3,030	-28.64	Very disadvantaged
Castle A	1,125.00	-0.48	Marginally below average
Custom House	367	-6.97	Marginally below average
Dock B	1,255.00	-0.83	Marginally below average
Galvone B	739.00	-33.24	Extremely disadvantaged
Glenworth A	641.00	-10.35	Disadvantaged
Glentworth B	1,218.00	-16.22	Disadvantaged
Glentworth C	555.00	-27.73	Very disadvantaged
John's A	747.00	-44.92	Extremely disadvantaged
John's B	1,038.00	-20.18	Very disadvantaged
Kileely A	1,455	-29.61	Very disadvantaged
Kileely B	890.00	-17.44	Disadvantaged
Market	2,253.00	-4.83	Marginally below average
Prospect A	1,061.00	-18.06	Disadvantaged
Prospect B	647.00	-26.89	Very disadvantaged
Rathbane	1,848.00	-25.65	Very disadvantaged
Shannon A	1,299.00	8.58	Marginally below average
Shannon B	1,242.00	-0.09	Marginally below average
Singland A	1,651.00	-21.18	Very disadvantaged
St. Laurence	988	-21.62	Very disadvantaged

Table 15 Extremely Disadvantaged Small Areas in Limerick City

Electoral Division	Small Area ID	HP Deprivation Index Score	
Ballinacurra B	128006001	-41.70	Extremely Disadvantaged
Ballynanty	128007004	-33.54	Extremely Disadvantaged
	128007005	-39.09	Extremely Disadvantaged
	128007007	-39.04	Extremely Disadvantaged
	128007010	-31.67	Extremely Disadvantaged
	128007013	-31.04	Extremely Disadvantaged
Galvone B	128020004	-37.02	Extremely Disadvantaged
	128020001	-43.97	Extremely Disadvantaged
	128020002	-44.01	Extremely Disadvantaged
Glentworth C	128023001	-30.30	Extremely Disadvantaged
John's A	128024004	-35.12	Extremely Disadvantaged
	128024005/128024003	-45.58	Extremely Disadvantaged
	128024002	-52.70	Extremely Disadvantaged
	128024001	-43.13	Extremely Disadvantaged
John's B	128001006/01/128025003	-32.30	Extremely Disadvantaged
Kileely A	128027005	-47.07	Extremely Disadvantaged
	128027002	-32.52	Extremely Disadvantaged
Prospect B	128031003	-39.99	Extremely Disadvantaged
	128031002	-36.20	Extremely Disadvantaged
Rathbane	128032005	-33.50	Extremely Disadvantaged
	128032002	-33.40	Extremely Disadvantaged

Appendix 2 - Principal and staff survey question on students' needs

How many of your students have needs in the following areas?

	None (1)	A few (6)	Some (2)	Many (3)	All or most (4)	I don't know (5)
Clothing (2)	◯	◯	◯	◯	◯	◯
Community context (needs arising from inequalities in the community, e.g., community violence, lack of services, etc.) (3)	◯	◯	◯	◯	◯	◯
English as an Additional Language (EAL) (4)	◯	◯	◯	◯	◯	◯
Emotional/behavioural (5)	◯	◯	◯	◯	◯	◯
Family Context: Addiction (6)	◯	◯	◯	◯	◯	◯
Family Context: Death of a parent or family member. (7)	◯	◯	◯	◯	◯	◯
Family Context: Domestic violence (8)	◯	◯	◯	◯	◯	◯
Family Context: Homelessness (9)	◯	◯	◯	◯	◯	◯
Family Context: Housing issues (10)	◯	◯	◯	◯	◯	◯
Family Context: Separation/divorce/single parent family (11)	◯	◯	◯	◯	◯	◯
Family Context: Mental health of a parent/carer (12)	◯	◯	◯	◯	◯	◯
Family Context: Parent/carer with Special Educational Needs (13)	◯	◯	◯	◯	◯	◯

	None (1)	A few (6)	Some (2)	Many (3)	All or most (4)	I don't know (5)
Attendance: Linked to EWO (14)	○	○	○	○	○	○
Attendance: Poor attendance but not linked to EWO (15)	○	○	○	○	○	○
Attendance: Punctuality (16)	○	○	○	○	○	○
Attendance: School refusal (17)	○	○	○	○	○	○
Attendance: Leaving school premises early while unaccompanied without permission. (18)	○	○	○	○	○	○
Student with an assigned social worker (19)	○	○	○	○	○	○
Living in Care (20)	○	○	○	○	○	○
Intellectual (21)	○	○	○	○	○	○
Mental health (22)	○	○	○	○	○	○
Nutrition (23)	○	○	○	○	○	○
General health (24)	○	○	○	○	○	○
Social skills (25)	○	○	○	○	○	○
Speech and language (26)	○	○	○	○	○	○
Physical ability (27)	○	○	○	○	○	○
Substance abuse (28)	○	○	○	○	○	○

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