Appendix O Online Focus Groups 2 – 5: Content Analysis
Focus Group 2: The Maroondah Approach to Communication Services (MACS)
An Integrated System for Paediatric Service Delivery:

BACKGROUND INFORMATION ON THE MODEL AND SERVICE: (as compiled by the guest speaker and from the discussion based around the model)

- utilises a modified version of the Maroondah Approach.
- is located in a country area.
- has a staffing of two OTs, with only 0.5 Full Time Equivalents (FTE) allocated to Paediatrics. In reality this probably extends to near 1.0 FTE.
- currently in the process of developing a Paediatric service delivery model that is consistent for Dietetics, Podiatry, Speech Pathology, OT, and Physiotherapy, and will also involve standard developmental screening at point of entry.
- It is moving away from a "therapy until cured" model to a "provide assistance – educate those involved and then monitor" model, with reasonable success.

The following is a brief description of the MACS system:

The guest speaker did the training in March 2000. It is a system designed by Speech Pathologists but also being trialed in other disciplines throughout the country. The service plans to implement MACS across all disciplines, and it is currently in use by the Speech Pathology Dept.

The MACS process is somewhat complicated - it is a system of case management, aimed at reducing the stress levels of clinicians and empowering families to take control of their children’s therapy services. There are several aspects of the programme that enable this to happen.

Timetabling – The department’s paediatric timetable is programmed at the beginning of the year. The number of assessments, reviews, groups, etc. is predetermined. Therapists have a standard timetable into which appointments are booked for them, e.g. a therapist may have two slots available for assessments per week – and who is seen is determined by senior/other staff. Clinicians do not have to worry about being busy or slow periods, work levels are predetermined. Two assessment slots per week exist with time scheduled directly after the assessment for the report. A comprehensive assessment and goal setting process occur with the family. Clients are then scheduled for the next available group programme. Home Programme ideas are then given in the meantime to both parents and other organisations involved.

Therapy Cycles – All clients are seen on a predetermined treatment cycle (e.g. 8, 10, 12 weeks). Almost all therapy is via groups, and after intervention and the allocated length of cycle, it is up to families to initiate contact for reviews. To ensure that everyone doesn’t book in for the same week, families are allocated a colour on entry to the service, and a list of review weeks available for that colour throughout the year. They then ring in when their colour is due and make an appointment. If they have not called within 3 months of the cycle completion they are discharged. Discharge also occurs if any three appointments are missed without cancellation. (Not necessarily consecutive). Letters are sent after each DNA reminding them of the policy. Families may re-enter the system, but must go back through the waiting list/assessment process.

The MACS system has an inbuilt register of clients who have not made contact for review. This may provide an opportunity for modification of the system by considering further contact with the family at this point.
Parent Training Sessions – No family can commence therapy without attending one of these sessions. These sessions cover information to train the parents as mini therapists, expectations of parents in groups, DNA policies, etc.

Pre - written group formats/Simplified Reporting Procedures – These groups are like individual treatment sessions but all being seen at the same time. They are generally a series of stations, and each parent is shown how to work on the level that the child is aiming for. Therapists do not have to do any preparation. This is done by means of an assistant who prepares the room and packs up afterwards. (Of interest – they charge $5 per person per group). Assessment pro formas are highly structured and take no more than ½ hour to complete.

There is no limit on the number of groups a child can attend. However, after a couple the parents usually feel skilled enough to follow a home programme, or they are in a school/ kindergarten environment which can take on that role – if goals and activity suggestions are provided. The OT then provides reviews for monitoring and upgrading.

This approach has been fully implemented by the Speech Pathology for 1 year now, and has significantly reduced their stress levels with regard to high demand. It has also given them a structure for discharging non-attenders who drain the capacity of the service. Whilst the system’s inflexibility may be perceived as a weakness of the model, it is this that gives it strength in reducing therapists’ stress levels. This is important for retention of staff and continuity of service provision.

There have been no complaints about the systems and a follow up focus group indicated good support for the system. Paediatric disciplines. The OT department has used parts of the process (timetabling – although this was already in the process) and DNA procedures over the last year also. These have been very effective. The OTs are very keen to implement the colour coding parent initiated review procedures.

The guest speaker reported that all staff have agreed to the new process in principle and have supported the idea of a set of “rules” for clients. All agreed that simplicity would aid access. The guest speaker mentioned that she is not sure whether they all realise the impact of the changes and that the actual implementation of the process would be a challenge.

Waiting lists are meant to be addressed through this system, as you identify how many assessments and review slots are required to maintain previous years referral rates and slot them in the programme. This worked well for Maroondah Hospital with a staffing of 4-5 therapists. However it has not been as successful for our Speech Pathology dept. of 2 clinicians. The reason for this appears to be that they simply do not have the capacity to deal with the number of referrals.

Some families do not have the capacity to follow through with the procedures. Exceptions are made for these families. It is up to the therapist to identify this and alter expectations. However, this should be the exception and only for families with intellectual/mental health impairments, etc. not general lack of interest.

The service does not have the critical mass to run specific pre-written programmes for specific goals. The groups need to be able to incorporate a wide range of goals, depending on the children present. The service has been able to overcome this, however, by running general fine motor skill groups (for example), with a predeteremined format. Activities are then chosen on a week-to-week basis.
How this can be applied on a Multi D basis – the service is facing questions such as:

- Do parents attend training sessions for each discipline (preferably not) but how can one session meet everyone’s needs.

- How can colour allocations, etc. be used across the board – the MACS is a very manual system (uses card files) – therefore everyone will need access to the same information- and will this affect the spread of work (if colours are already allocated before OT sees a number of children – will we end up with two many “pink” children booking in for reviews at the same time?)

- The service believes that children and their families entering this service should take an active role in their therapy and that MACS facilitates this. Clients should also receive one unified service delivery model, with the same policies and procedures regardless of the discipline providing the service. To that end, if one part of the service uses MACS, then all need to. The challenge now is how to do that effectively and to the benefit of the service’s consumer group.

STRENGTHS OF THE MODEL: (summarised version of the group discussion)

- Promoting parental responsibility and joint responsibility with parents
- An organised and structured system
- Parent training sessions, parent engagement and empowerment, with added benefits of parent support and networking, providing clearer understanding of what OT has to offer
- Parent training sessions which occur before the intervention process occurs
- The compulsory training session increases compliance with the treatment programme
- Pre-written group formats (which works better for Speech than OT). It does require some modification in terms of different client needs for OT.
- By providing parents the responsibility for reviews, frees up therapists to spend more time with families who are committed in regards to intervention
- Frees up time for therapists to spend on health promotion
- Pre-determined timetable and caseload of therapists: reducing stress levels and aids in effective time management, allowing the planning for and more time for professional development
- Avoidance of therapist burn out
- Therapy cycles facilitate better waiting list management
- Therapy cycles assist families in setting realistic goals upon reviewing results

WEAKNESSES OF THE MODEL: (summarised version of the group discussion)

- Strong adherence to the model might disadvantage some families, e.g. where parents are not able to attend (parents can attend any one training session provided monthly)

- The complexity of the review system and responsibility placed on parents
- Many families are not ready to start with parent training before the actual intervention process or at the specific time that the training is scheduled at
- Inflexibility of the model
- The application of MACS by one discipline may isolate that discipline for the rest of the team. One other service indicated that it did not occur within their service.
- Reduces flexibility in time of therapists
- The diverse nature of clients and individual needs make pre-planned groups difficult to implement
- Inclusion of this model into the many environments of a child seems to be difficult

APPLICATION OF THE MODEL: (summarised version of the group discussion)

- Incorporation of the approach by all disciplines is recommended
- A multi-D modified application is recommended
- Needs to be modified to suit the OT intervention process
- Seems to suit Speech Pathology better than OT due to the more diverse nature of the OT intervention process
- Modifications: a more specific process to identify those who are not capable of following the “rules” and reasonable allowances made accordingly. One service reported a flexible application of the review process
- A more flexible system with allowances for socio economic more disadvantaged clients
- Some views were that it was better suited for a metropolitan hospital which is department based rather than team based, where it originated.
- Others felt that it would be more suited to community health and rural settings where staffing is limited, with large caseloads and great potential need.
- Another mentioned that it would fit well where intervention focuses on impairment rather than occupational performance.
- Some organisations that provide services to clients over their lifespan felt that the use of a range of models throughout the lifespan is required

OTHER DISCUSSION RELATED TO THE MODEL: (summarised version of the group discussion)

- Guarding against turning parents into “mini therapists” when training parents
- Improving our skills as adult educators
- Interest in other programmes with a strong parent training focus, e.g. the Hanen Approach and Vicki Meade’s “Partners in Movement”
- Community based model versus a centre based model: the opportunities for therapists to learn from each other are limited in a community based model. Staff training becomes a priority when a transdisciplinary model is used
- A “peer support” system (a forum to share ideas and discuss issues) to facilitate cross training of therapists and support for less experienced therapists was suggested

The parents are involved first of all in a Parents only group to provide information on what the process is about, the process will be detailed to parents for the model called COPD. Class based service are provided for the children. The parents bring the child's groups for usually 1 hour and then participate in a 1 hour parents only group. After the children then attend classes. We hold morning and afternoon groups, e.g. school gardens starts at 12.30 and the parents session finishes at 2.30.

COPD is a model to enable the OTs with parents to set joint goals for their children and use them as the conclusion of each group. Parents sometimes find this difficult and unusual process initially. Parents who are familiar with the process have no problems and find it a model tool to understand what OT is working on with their child and we tend to be involved in the process.
Focus Group 3: NHS: OT SERVICES for children and families

BACKGROUND INFORMATION ON THE MODEL: (as compiled by the guest speaker and from the discussion based around the model)

One full time permanent OT position and a 0.2FTE temporary contract in Community Health for children and families living within the catchment area. The Head of Discipline also contributes approximately half a day per week.

The aim of the service:

To develop, provide and evaluate high quality community health Occupational Therapy services including:

- health promotion services
- therapeutic services
- community development initiatives
  within a multi-disciplinary context.

Client group:

OT services in Community Health focus on early intervention for children prior to school commencement (i.e. 0-6 years). Services are provided as part of a multi-disciplinary service for children at risk of or identified with developmental delay and their families.

Services offered:

A range of discipline specific and multi-disciplinary assessment and therapy services are provided. All groups are supported with specific time devoted to parents and this focuses on providing parents with opportunity to gain support, new knowledge, skills and confidence.

Parent involvement: Parents report on the value of being able to link and network with other parents. Guest speakers at the parents groups are determined by parents and have included child psychologists, managers of special education services within DETE and nutritionists. Parents are integral in planning, implementing and evaluating therapy services. Components of COPM (The Canadian Occupational Performance Measure - a standardised, client-centred goal setting tool) are used to establish and evaluate individual goals for children. Parents contribute to the planning of group sessions on a weekly basis through feedback in the parent’s session following the children’s group.

The parents are involved first of all in a Parents Only group to provide information regarding OT, the group, answer any questions the parents have and to set goals with the parents for their child using COPM. Creche services are provided for the children. The parents attend the children’s groups for usually 1 hour and then participate in a 1 hour parents only group. All the children then attend creche. We hold morning and/or afternoon groups, e.g. school readiness starts at 12.30 and the parents session finishes at 2.30.

COPM: The OTs use the COPM with parents to set joint goals for their children and rate these at the conclusion of each group. Parents sometimes find this a difficult and unusual process initially. Parents who are familiar with the process have no problems and find it a useful tool to understand what OT is working on with their child and are keen to be involved in the process.
The service uses a modified version of the COPM pre- and post group each term. After a Parents Only session where we provide information about how to use the COPM and the importance of parents being involved in this process we set goals individually with each parent. We then use these goals to report on progress for the child each group session and to guide our planning. At the completion of the group we again meet with each parent individually and review progress towards goals for their children, i.e. they rate how they feel their child is performing in the particular goal area and also how satisfied they are with their child’s performance.

Screening Tool: A visual-motor screening tool developed by OT is utilised by Speech Pathologists (SPs) to screen the children they see and make referrals to OT as appropriate. SPs are often the first contact for the health service and so they refer on to OT and Psychology services. Training has been and is provided to the SP using the tool. The SP discusses the referral to OT prior to making it.

The screen is a simple visual-motor tool which asks for pencil grip, copying skills and free drawing skills. It was designed in conjunction with SPs and was aimed at standardising referrals to OT thereby ensuring that children were not being missed. Its simplicity allows it to be conducted easily within a normal SP session and does not require the SP to interpret what they see.

Children & Youth Health already carry out screenings for children and refer to OT as relevant. Psychology, Community Health Nursing and Social Work are also involved in the EI team. It was felt at the time of developing the tool that SP could easily incorporate the simple screen into their assessment process without them having to do any additional work or make decisions re whether to refer or not. One area of delayed development is marked on the screening tool and they refer.

Multi-D assessments and intervention: the HELP checklist for younger children is used, particularly for those children who are part of a joint speech pathology and occupational therapy assessment group.

For older children OTs tend to use their own assessments, but share a joint assessment time in which lots of observation and information can be gathered once rather than repeated in a number of assessments.

The service has child psychologists within their child team and social work within their adult team, who they refer to. Child psychologists are also usually involved in parent sessions of all of the therapy groups and some children sessions as well. In addition to this the service has a parent support group for mums, facilitated by OT and social work and active fathering groups that run for 6 weeks and leaders rotate through disciplines, this term is has been psychology and speech pathology. The service also offers a STAR club which is a group run primarily by psychologists and co-leaders again rotate each term (this term is speech). This programme looks at supporting children who have witnessed or experienced family violence.

Group intervention: The children are in closed groups for a term at a time (usually 1 week of parents only planning and 8 weeks of group program). OT clinic is held fortnightly during the term time. Some children may need to attend three out of four terms of group per year but this depends on the needs of the child.

During the Parents Only sessions following the children’s groups, OTs and parents discuss issues concerning their child, e.g. kindergarten, school system, supports available, etc. and where possible will advocate for these parents. Some of the parents whose children have
attended therapy groups now attend a mums support group which is co-facilitated by OT and Social Work.

**Community health work:** As community health workers OTs are also involved in providing a range of other services including health promotion, education and community development. These activities support the direct client services, e.g. being involved in advocacy to improve services for children, or working with other professionals to improve screening of young children.

Due to limited staff resources, community development and health promotion work focuses on children and families in turn supporting and complimenting the services provided by the early intervention team.

It is really difficult to separate the community development work from the other services provided as they overlap e.g. parents groups often have a community development focus. It is more about the approach to working with children and families. The service currently does not have the resources to run specific community development programs / projects on their own. Consequently they work a lot with other disciplines and agencies to be a part of projects such as DETE Pathways Project, etc.

Some specific examples:

- **Pathways for Families** – based on the New Pin (UK) and Kids ‘n’ You (Northern Adelaide) model which supports families through education, group support, drop-in support, peer support and therapy services. Onkaparinga Council and NHS (and many other services for families) are involved in the development of this program for the outer southern region. They are keen to link women who have participated in a support group for mum’s (co-led with a Social Worker) into this program. The vision is that eventually strong links and networks will exist between therapy services provided for children and the Pathways for Families Program.

- **Motor Magic** – is a jointly funded DETE/NHS project looking at opportunities/strategies for providing OT services to children with the kindergarten setting.

**Things that are working well:**

The service aims to provide a comprehensive service that focuses equally on children and parents/careers. Like many agencies, services (groups/assessments) are planned and provided jointly with other disciplines. They continue to think about other services/people who can support us in our work, particularly in supporting parents. So some of these include Southern Women’s Community Health Service, Southern Domestic Violence Service, DETE, Council and the Carer’s Association.

Parents report to us that they value:

- Opportunities to link with other parents (e.g. parent sessions).

- Opportunities to access other information, resources, skills in parent sessions, e.g. child psychologists.
Opportunities to be involved in group and service evaluation and contribute to group planning.

A flexible service in which lots of communication happens between parents and disciplines involved with their children.

Opportunities to learn more about how to support their children from the team and from other parents.

That they have access to a regular service – parents are really aware of lack of services/support.

**Things that are not working as well:**

- The service is not currently in a position to be able to provide services for children and their families who reside outside the catchment area or those children who have commenced school.
- OTs often struggle to meet the complex social and emotional needs of families (both children and parents). As a result they often feel that therapy input does not necessarily meet the needs of families and that the important needs are those family support/counselling and parenting skills/confidence.
- Waiting times for 1:1 psychological counselling are long and limited resources is a continual struggle.

**Future/current planning:**

- Involvement in a program for fathers focusing on issues of parenting specific to this group.
- Strategies are being discussed to address issues of domestic violence and its impact on children. As early intervention workers, OTs are thinking about trialing ways of talking with parents about violence and its impact.
- Strategies and programs aimed at supporting families immediately on referral to any early intervention service – initial ideas that have been discussed include:
  - Issues of parent support and advocacy
  - Importance of early childhood years
  - Potential influences on early childhood development, e.g. domestic violence, nutrition, nurturing, behaviour management
  - Linking with other community resources (reducing isolation), e.g. playgroup association, Southern Childcare Support Program, Neighbourhood houses and parenting support groups.

**STRENGTHS OF THE MODEL: (summarised version of the group discussion)**

- The links with lots of other agencies.
- The emphasis on health promotion.
- Multi-discipline assessments/screenings.
- Parental involvement in planning, goal setting, intervention and progress.
- Individual planning with families.
- Parent education.
- The recognition of the importance of parent networking.
- It provides informal social contact for parents and children with like issues.
The ability to work on broader issues such as domestic violence and the impact this has on children. Relevancy of services are ensured by keeping the context of families in mind.

The model provides for a continuum of involvement from "hands-on" therapy to greater involvement of parents and the local community about broader issues.

The diversity of services and links that the service has with others (disciplines, programs agencies) and with parents.

A pleasant and non-threatening environment: conducive to parents and children.

The community based setting enables much easier access and links to other related services.

WEAKNESSES OF THE MODEL: (summarised version of the group discussion)

Restriction to the group service provision: some families are not able to travel to a venue for social, economic or personal reasons and the question was raised whether this is truly family centered. Recognition is given to limited resources.

Cessation of services when children attend school full-time.

APPLICATION OF THE MODEL: (summarised version of the group discussion)

Applied best a community health setting where funding is determined in a different way than hospital funding is.

Relevant strategies which can be applied to the hospital setting including: parent involvement in planning, parent training, joint projects with other agencies especially DETE.

A broad application: This mix of group intervention, parent education, parent networking and parent feedback and involvement in planning are essential to the provision of EI services for a broad range of children.

Group intervention appropriate for children who do not require intensive individual intervention.

OTHER DISCUSSION RELATED TO THE MODEL: (summarised version of the group discussion)

New Pin and Kids ‘n’ You programs:

Interest expressed by participants to share information.

COPM:

No training as such is required to administer.

The package can be purchased - One of the OT assessment suppliers suggested.

Other services expressed that they have also been using or are planning to use the COPM.

Case Management Role:

The service under discussion does not have a formal case management role, but has a coordinating/centralising role.

Another service reported that it has a key contact person for each child. This person is chosen by the family and is usually the 'primary therapist', i.e.- child's needs determine this (e.g. mainly speech needs so speech pathologist is key contact). The
key contact chairs the meetings, follows up any recommendations and helps families to access services/ follow up recommendations.

- The service also has a team approach to case management through the 'Child Health Sub Team Integrated Plan for Services...'CHIPS document'. They have regular meetings for children receiving 2 or more services where they talk about the issues/ therapy needs and prioritise goals and services. The aims is to ensure consistency re treatment goals and strategies to ensure that families are not overwhelmed by having to access lots of different appointments.

Joint DETE projects:

- A service mentioned that other regions have attempted similar initiatives with regards to joint programmes with DETE.
- Question raised: whether it is an idea to pool these projects together to create more sustainable change with DETE and OT services.
- The service under discussion mentioned that it was a valuable experience to develop stronger links and working relationships with the manager of special education services in the area as she is also the person who has the power to allocate funds (within her own budget restrictions of course) and this is how this initial amount of small money was allocated to O.T. A social planning alliance has also been developed that involves lots of different sectors including health and education and again the manager within DETE and the service’s managers attend these meetings, so the issues are being discussed often at a senior management level which in turn reports to DHS.
Focus Group 4: The Hanen Approach

BACKGROUND INFORMATION ON THE MODEL: (Summarised contribution provided by Guest Speaker)

Background on the organisation:

- The service provides services for children aged 0-18 with physical disabilities across S.A.
- Approximately 950 clients.
- 17.8 FTE speech pathologists (SP), 7 speech pathology assistants, approximately equal numbers of Occupational Therapists (OT) and Physiotherapists (PT), 6 psychologists.
- Teams usually include SP, OT, PT and psychologists, dependent on client and family needs and priorities. 
- 6 regions, each with regional office from which therapists provide a community based service in clients homes, childcare, pre-school, respite, recreation, etc.
- Outreach services, 12 rural areas across the state. Provide consultative support to local service providers who have primary role with the client.
- Regional Manager administers services, may also take a role in eligibility process, planning, review and co-ordination of services with families and clients.

Service Model: The Hanen Approach

- The Hanen Institute is located in Canada and continues to oversee the programme development and provision of training internationally.
- The approach involves provision of any of a number of group based training/education programmes.
- Hanen programmes designed for specific groups: parents of children with Language delay or disorder, Early Childhood workers, parents of children with Autism Spectrum Disorders, teenage parents. All programmes focus on facilitating development for children with or at risk for language delays/disorders.
- The service has 9 speech pathologists trained as presenters of the parent programme for parents of children with language delay 'It Takes Two to Talk'.
- Hanen presenters attend a 3-day ‘train-the-trainer’ workshop. To maintain the certification, presenters must run at least two programmes over two year period.

Programme comprises:

- Orientation for information about the programme, its structure, expectations and responsibilities
- nine 2 1/2 hour group sessions attended by between 6 and 8 families run by two Hanen trained therapists
The topics are as follows:

- Allow Your Child to Lead
- Adapt to Share the Moment
- Add Language and Experience
- Review, Share experiences
- Play the ‘3A’ Way (3a stands for Adapt, Allow and Add, and it is the Acronym used to describe the summary of the Strategies taught in Hanen)
- Making the most of Music
- Sharing Books
- Creating Together
- Closing session

3 home-video-ing ‘coaching’ sessions. Speech pathologist video tapes adult/child interactions at home, usually around a framework of applying some of the strategies from the group sessions. These are reviewed and used as a learning aid on the home visit, and also are used within the group sessions. Clinician may ‘coach’ the adult within these sessions.

Children are given a ‘Hanen’ level (1 to 4), based on information from their family and their usual clinician. This relates to the level of the child’s functional communication level.

Suitable for children up to the level of consistently combining two ‘words’. If possible, group comprises parents of children who are homogenous, but this is not mandatory.

Incorporates Adult Learning Theory, uses a ‘4P’ approach (Prepare, Present, Practise and Personalise) which takes account of people’s various learning styles.

Incorporates feedback throughout and at the completion of the programme.

The service has now run 5 programmes, this year we will run two concurrently starting in May, one Southern metro, one northern metro. Up to two more this year, dependent on demand.

What Works Well:

- Family centred.
- Explicitly targets parent education/learning versus 1:1 direct therapy by therapist.
- Piggybacks on the refinements/development work/research/resource materials/20 + years experience and improvements of the Hanen Institute.
Learning framework provides parents an opportunity to practice new skills with support, and then at home in their own situation.

Family feedback has been very positive. Parents report the group format is a great opportunity to meet with other parents from whom they get support, information, and ideas.

The service's speech pathology unit had been trying to develop a parent training programme. They felt some things they had experienced were associated with the more traditional service style - parents feeling that they had no role or skills, that 1:1 therapy was the 'answer', that therapy was the therapist doing 'things' to the child, x times/week/month, etc, that more was always better etc. Hanen provides a framework to attach to.

Involvement in a Hanen programme 'lifts' what is really fairly common knowledge to a level, and provided a framework for this knowledge, that makes it available to be readily used by families in relation to their child. The information presented isn't earth-shaking or new, it is just the way it is presented.

Parent's ability to goal set for their child is greatly supported: The programme includes quite a lot of information about the normal processes of language development. Parents are given information at a deeper level than they would usually be able to access (meta-linguistic?) about language development and communication. This information is also provided to them in an accessible format, incorporating adult learning theory. The information is put into a personal knowledge framework, so that parents are better able to determine where they and their child want to go next.

The programme focuses on communication being meaningful and functional for their child in their environment. Aside from anything else, it gives the parent a shared vocabulary with the therapist which they feel comfortable and at home with, to talk about language and communication development, and the strategies that they might apply.

Parents develop increased confidence in their knowledge and skills, not only with their own child, but with the whole area of communication development. Parents get a lot of explicit and supported practise at goal setting as a part of learning every concept covered within the programme.

The parent group proved an excellent forum to get some honest and open discussion amongst the parents about some of the interventions/actions that therapists may suggest (such as Augmentative and Alternative Communication). Other parents often act as advocates for the intervention, including talking about their own initial negative feelings, and what their experiences have been.

Parents love the video-taping by the end of the programme, though everyone is initially nervous about it, and they provide a great opportunity for learning and change.

What Hasn't Worked so Well:

- Very resource intensive.
- Childcare provision required.
- Staff are required for an intensive period to work a night at least weekly.
- Because the training is expensive, difficult to access, and sited in an individual or individuals, it is hard to organise to ensure that we can continue to offer it as a service delivery option.
- Logistically a 'challenge': Doesn't mix well logistically with our usual workload allocation and team approach at a service management level - because the clinician is intensely busy, but for discrete periods of time. Difficult to provide them with a caseload in the organisation when the demand is structured like this, as therapists are usually allocated to age related or geographical teams and see clients on a
regular/on-going basis. It has been difficult to pull scarce resources 'out' of existent services to apply to providing the Hanen programme, particularly because the demand is unpredictable. Services are usually provided over an extended period of time and on a regular basis, i.e. Early Intervention team run a weekly group, and each member of the team visits the client at home or at child-care weekly. It makes the running of the general programme difficult if the EI team speech pathologist is also running a Hanen programme. Ideally the guest speaker would love to move to offering Hanen as the standard Speech Pathology intervention model for all of our Early Intervention families whose children have language delays or disorders, which might make it easier to assign Hanen to someone's caseload. At the moment, because Hanen is still relatively new and growing, there are logistical issues in trying to mix service delivery models, being offered by the same clinician.

STRENGTHS OF THE MODEL: (summarised version of the group discussion)

- The focus on adult learning and parent training rather than on being dependent on the therapist for 'hands on' therapy.
- The idea of videotaping: an excellent way for parents to get feedback, and to become aware and critique themselves, more convincing than talks and demonstration from therapist.
- The work with parents, especially sharing their experiences in groups. This increases their role in the therapy process. The parent training increases their capacity and there is the option of parents going on to train other parents which is a good health promotion strategy.
- The adult training program and a lot of opportunities for practice. Building of skills and confidence.

WEAKNESSES OF THE MODEL: (summarised version of the group discussion)

- Labour intensive and time consuming, requires full devotion from both parties (parents & therapist).
- Some parents may find videoing too confronting
- This model may be more suitable for some parents than others: some would demand a lot more of the facilitator's group management skills, etc.

APPLICATION OF THE MODEL: (summarised version of the group discussion)

The guest speaker feels that some of the aspects can be applied to OT:

- the specific and explicit parent/carer training focus
- the group format
- the incorporation of home visits and video-ing of the child and parent interacting
- the use of the videos both in situ as a training/coaching opportunity, and in the group sessions
- the '4P' approach can be applied to any concept. The sessions incorporate a number of different 4p cycles
- The guest speaker thinks that the model could be adapted for parents of children who receive their services in a centre-based model, maybe along the lines of: the programme is offered to all parents as an introduction to the service, either before
individual therapy commences or as well as individual therapy. Attention would need to be given to travel, economic, child-care related access issues so that it was accessible to all parents. Getting the numbers would be more difficult possibly.

- Can be applied to any etiology of the language delay or disorder or any age: the information, strategies, and process seem to work well regardless.

The Early Intervention Team is made up of 4 0.5 FTE allied health staff, including a speech pathologist, clinical psychologist, physiotherapist, and the occupational therapist (OT). The service seeks families with children from 0-8 years of age with identified or suspected difficulties in at least 1 area of development, while being at risk of delay in another area(s) of development. These areas of delay include self-help skills, cognitive skills, social-emotional skills, sensory-motor skills, and communication skills. The majority of school age children the OT helps have learning difficulties, including fine motor difficulties, and quite often have an sensory integration basis. Thus, in total, the families who join the program have a make up of mild difficulties and individual needs which is catered for in the most appropriate way possible, through shifting work with each family in turn. Services offered include: testing, assessment, individual or group therapy, group programs, depending on client need; parent support and counselling; specialist parenting programs; advocacy; and community links (i.e. linking families to local programs like Kindergarten). “Learning begins far earlier than often recognized....the integrated approach is central to any therapy, but including resources for parents, teachers, and related agencies (i.e. special education, health, and other services).

The OT began working at this organization as a new graduate 7 years ago, and was encouraged to expand her role into pediatrics. Her predecessor had not offered a pediatric service prior to her arrival, and she could “start from scratch”, not being locked into previous expectations or demands. As her first referrals were school children, who came from local Mentor Guidance Officers (counseling psychologist employed by DTES), that is where the needs were.

Some useful tips on how the integrated care services within the school system are as follows:

- Contacted and met with each school principal and Special Educator (both public and private) at their schools, at their convenience. At these meetings, the OT explained her role and left them with promotional material regarding services she could offer that complemented the valuable work that teachers, school support programs, and special education were providing. She suggested that at the staff’s convenience, she could make herself available for Primary staff meetings. She also directed classroom staff may have, and to provide additional information as needed.

From these meetings, she received numerous referrals and considerable interest from the majority of teaching staff, particularly Special Educators and R-1 teachers. Teachers were particularly interested in learning as much as they could do to help their students, which the OT found especially encouraging, and she received, and continues to receive, numerous requests to provide workshop sessions on different topics within annual Teacher Training and Development Days at different schools.
Focus group 5: OT IN THE SCHOOL SYSTEM

BACKGROUND INFORMATION ON THE MODEL: (as compiled by the guest speaker and from the discussion based around the model)

The organisation is a community health service servicing a population of approximately 30,000 people, and with an annual growth rate of 26%, the second highest in the state. Services we offered include: Social Work, Mental Health, Drug and Alcohol Counselling, Diabetes Education and Health Promotion, Dietetics, Speech Pathology, Community Nursing, Domiciliary Care, Women’s Health, Youth Health, Aboriginal Health, Dementia Respite, Aged Care Assessment, and Early Intervention.

The Early Intervention Team is made up of 4.05 FTE allied health staff, including: a speech pathologist, clinical psychologist, physiotherapist, and the occupational therapist (OT). The service sees families with children from 0-8 years of age with identified or suspected difficulty in at least 1 area of development, while being ‘at risk’ of delay in another area(s) of development. These areas of delay include: self-help skills, cognitive skills, social-emotional skills, sensory-motor skills, and communication skills. The majority of school age clients the OT works with have learning difficulties, including fine motor difficulties, and quite often with an Sensory Integration basis. Thus, in total, the families who join the program have a wide range of difficulties and individual needs which is catered for in the most appropriate way possible, through negotiation with each family in turn. Services offered include: screening; assessment; individual or group therapy (largely group programs, depending on client’s needs); parental support and counselling; specialist parenting programs; advocacy; community links (i.e. linking families to local programs like Kindergym); ‘Learning’ library (similar to toy library, but including resources for parents, teachers, and school age children); health promotion programs; consultancy; and community education workshops (for families, teachers, and other caregivers).

The OT began working at this organisation as a new graduate 7 years ago, and was encouraged to expand her role into paediatrics. Her predecessors had not offered a paediatric service prior to her arrival, and she could ‘start from scratch’, not being locked into prior expectations or demands. As her first referrals were school children, who came from a local District Guidance Officer (educational psychologist employed by DETE), that is where she began her services.

Some useful tips on how she integrated her services within the school system are as follows:

- Contacted and met with each school principal and Special Educator (both public and private) at their schools, at their convenience. At these meetings, the OT explained her role and left them with promotional material regarding services she could offer that complemented the valuable work that teachers, school support programs, and special education were providing. She suggested that at the staff’s convenience, she could make herself available for Primary staff meetings, to answer any questions staff may have, and to provide additional information as requested;

- From these meetings, she received numerous referrals and considerable interest from the majority of teaching staff, particularly Special Educators and R-1 teachers. Teachers were particularly interested in learning as much as they could to help their students, which the OT found especially encouraging, and she received, and continue to receive numerous requests to provide workshop sessions on different topics within annual Teacher Training and Development Days at different schools;
Whenever visiting a school, she was encouraged to make herself available to

teaching staff during break times (e.g. recess and lunch), so they could discuss

potential referrals with the OT, seek advice, or receive information, which she also

found very helpful. She also made time available for Special Educators, who

proved to be invaluable sources of support, resources, and specific information on

the children she was working with, but who also appreciated feedback from the OT

regarding the progress of individual children they too were working with;

The OT also made sure that she became familiar with all the office staff, and vice

versa, at each of the schools she attended, whom she frequently relied upon to book

rooms, chase up appointments, and assist in contacting teachers.

The OT has moved on from working as a sole practitioner with school aged children from the

Health Service, to part of the half-time EI team, so some things have changed, but the general

process for children to be linked into OT services are as follows:

- Referral is received by phone, verbal message, faxed form, or even by drop-in visit
to the service. Referral details are taken, then a form is provided to the referrer
which needs to be completed, with parent’s signature as consent for assessment.
This generally occurs within 2 weeks;

- There is an EI allocation meeting every week and each child is allocated a case
manager, who is the primary service provider responsible for organising an initial
assessment and for coordinating ongoing follow-up from the EI team. The team all
use a generic clinical history tool with the child’s family to gain useful background
information and highlight possible areas of difficulty that need to be followed up by
other members of the team or other local programs. Generally, however it is the OT
and the psychologist who see the majority of school age children between them,
due to their expertise in this area, and the type of difficulties the children and
families referred are experiencing;

- Assessment(s) are usually conducted in a setting in which the child's problems can
be viewed in context, or depending on familial needs. The majority of assessments
for school age children would be divided between the child’s school and the Health
Service however, with classroom observations of the child being extremely
important in the case of some children (those with behavioural or attentional
problems in particular, but also with some children’s specific learning difficulties,
which may be highlighted best within the classroom setting);

- Once assessment is completed, a parent feedback session is organised to feed back
the child’s report information and recommendations, and develop a ‘Family Service
Plan’ in which goals are formulated with the child’s family, a Family review
meeting time is set, and options for follow up are agreed and set in motion;

- Any one or more of the previous service options will be implemented, in whatever
setting has been agreed as the most appropriate for the child, that also best fits
within what the EI team can offer at the time, which will either be the school, or
Health Service;

- The OT works with a well trained and informed team who all have some basic
skilling in picking up major preschooler’s difficulties that relate to OT (e.g.
drawing/cutting or manipulation skills issues or self-help problems), but they still
rely on the OT for full assessments to pinpoint the exact difficulty and cause (where
possible) of the difficulties, in order for them to more specifically target their
intervention activities/suggestions. When treating preschoolers, they all work as a
team with planning the intervention, so they all take it in turns to document
children’s group progress in fine motor skill areas for e.g. (so others can become
more experienced in what to look for), and they plan the fine motor (& other skill
areas) activities together - with some consultation with the OT as needed. This
shares the load & enables the team to still run the same group confidently, even if the OT is away for a week.

- In regards to identification of sensory problems in the younger group, the team uses the 'Dunn Sensory Profile' between them, & the OT helps each team member to interpret the results, and write up the report, but she is usually responsible for writing up most of the recommendations section herself. The team have commented on how using it has given them a greater insight into sensory reasons for children's behaviour and development.

- Family involvement is always tricky if working in the school setting, and often it's not appropriate to include the parents in their child's school therapy program for various reasons, but it's essential that parents assist their child as much as they are able, with the OT's guidance. The OT thus usually supplies a short home activity each week (that is generally a sustainable resource families can continue to use throughout the term), that they are requested to help their child with, and for their child to report back on at the next session. Parent workshops are sometimes also part of this process.

Of the 4 staff in the EI team, the OT's caseload is the busiest, because OTs specialise in so many different areas of children's development, she also has the most experience in the team, and her local knowledge and networks are such that referrals are often directed to her specifically. She thus has to be creative in her time management and very organised, so she makes sure that she is familiar with what each school has to offer in terms of support programs and staff, so she can link children into these programs if appropriate, rather than taking them all on board herself. She runs mostly small groups at all schools, which she finds works well for teachers and students alike (particularly for students' confidence, social skills, and fun!), and she trains teachers as much as possible to identify functional problems children are having, and provide them with the skills to address a number of these difficulties themselves, without necessitating OT referral, e.g. by providing triangular pencils, slant desks, move n' sit cushions, activity adaptation. Some of the topics of training the OT has provided are: Sensory Integration (SI) and its relationship to learning and classroom performance; SI general introduction and whole class 'sensory health' promotion ideas; handwriting assessment and intervention; sensory/gross motor skills identification and how to incorporate within the school day; fine motor assessment and intervention; what OT is/ how and when to refer/ how it complements the curriculum; sensory defensiveness behaviour identification and management strategies; auditory processing and phonological awareness skills identification and classroom strategies; how to adapt the Funastics program for children with learning difficulties or developmental disabilities; and 'How does your Engine Run?' - alertness/attention mechanism/ how it impacts on learning/classroom sensory diet strategies to promote attention and learning. The feedback from teachers is that they are highly appreciative of any skills training the OT can provide, so they can assist their students as much as possible within the classroom. The means children do not have to be constantly withdrawn for support, special education, or therapy - a philosophy the OT wholeheartedly agrees with, as it allows children to feel part of their class, rather than being 'different', and the less disruption to their daily routines, the better. This means that only the children with the most difficult and comprehensive of problems are referred to the OT services for follow up.

The most important trend the OT has noted in her work with school aged children over the last few years is how best to provide input to teachers. Rather than providing specific strategies for an individual child in a class that a teacher rarely has time to implement, and usually isolates the child from his peers, she provides as much skills/training and information to teachers as possible regarding strategies that address certain developmental difficulties that the whole class will benefit from, not just the 1 or 2 students the OT is working with. An example of this is scheduling of certain lessons or activities in the day for a sensory diet that promote optimal alertness/attention for learning. Of all the work the OT has done in schools
over the years, this is probably the most effective way she can reach a large number of children throughout an entire school, and have an impact on their development. Although group programs, individual programs, and parent workshops are also invaluable, thus a 2 pronged approach that combines both teacher/parent education and child therapy is her preferred option, which allows for understanding of children’s needs, greater sustainability of skills children learn in therapy, and generally, more rapid developmental progress.

STRENGTHS OF THE MODEL: (summarised version of the group discussion)

- The model utilises resources of those who spend most time with the children, therefore facilitating consistent support.
- It is a health promoting model with its emphasis on activities for the whole class.
- It addresses the issue of appropriate referral from referral sources.
- The initial effort made to be available for teachers within their own time frame is an important initial step to set up a positive regard for OT input.
- The parent workshops is a strength of the model.
- Overall the combination of hands on therapy, a school approach, and a parent involvement approach are all strengths of the model.
- Training of teachers.
- The process of getting to know office staff was also a very positive step.
- The concept of a weekly EI team allocation meeting.
- The use of a generic clinical history tool avoids duplication for parents, which is important.

WEAKNESSES OF THE MODEL: (summarised version of the group discussion)

- Developing links with schools takes time and energy and is a constantly evolving process as staff (both therapy and school) change. Finding the time to maintain these links with the current pressures of work is a potential difficulty.
- There is the potential when programs are run with larger groups of children for those in need not to get the more individualised help they need.
- Handover of the OT’s skill was raised as a concern. It runs the risk of OT services being "owned " by other professions. However, it does also facilitate the use of other people as resource. Concerns exist that teachers begin to use OT specific strategies. The guest speaker responded to this point by stating that this situation is not unique to OT and the DETE team of professionals find the consultation system very effective in reducing waiting lists and handling large caseloads. She has never experienced that she was losing her role as OT and she shared her experience of mutual collaboration and respect of each others’ roles as important in this consultation process. The advantage is that school staff are now able to handle the more minor cases themselves.

APPLICATION OF THE MODEL: (summarised version of the group discussion)

One participant felt that it may be a model that works better in smaller communities or where the catchment area is defined and small.

OTHER DISCUSSION RELATED TO THE MODEL: (summarised version of the group discussion)

- The guest speaker mentioned that with Partnerships 21 being brought in by some of the schools, some schools may be keen to put some money towards gaining OT services. This may be an opportunity for OTs to get into the school system.
• The guest speaker noted that the initial phase of collaboration and preparation when collaborating with the school system, is really important for the effectiveness of the programmes. Once a good network of teachers & Special Ed. staff is built up and they fully understanding the OT’s role, it does not take much effort to maintain further. Having a key link at each school (tends to use the Special Education teachers or Guidance Officer) where all school referrals can go through & communication can flow back to each school to is extremely helpful.

• Another suggestion by the guest speaker is the use of student placements to help sustain networks/model of practice. Fourth year student projects have been proven to be really useful to maintain links with schools, save you the time and effort in doing so.

• The guest speaker felt it is a good idea to share written handouts that are made from presentations amongst OTs to avoid recreating the wheel. Plans are in place for country OTs to set up a system of sharing their information resources.
### Evidence of critical reflection regarding model

"I am getting much better results today than a few years ago under other models."

### Evidence of introduction of the need for change to current service delivery models

"So, what we need is a better system."

### Evidence of demonstrating the nature of the problem - stigma and the deficiencies of current models of practice.

"...there is a real gap in terms of services - shortage of services but also once they leave Early Intervention, yet the expectations increase when they move more into the community."

### Evidence of commitment to change.

"Most of us are now moving away from traditional therapy to more collaborative approaches."

### Evidence of insight into the need for psychological housing, including the need for creative, relational, and emotional environments of services.

"So there was all the emphasis on "empathy."

### Evidence of internalisation of information.

"Those are the things that we need to be able to emphasise here and we need to work across different ideas and whenever we can adopt it here."

### Evidence of impact effect regarding the improvement of slopes in terms of...

"So at hand I was very keen to get a slope for the most pertinent part of the analysis for effectiveness."

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Evidence of analysis</th>
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</thead>
</table>
| Evidence of critical reflection regarding model                            | "I am getting much better results today than a few years ago under other models."
| Evidence of introduction of the need for change to current service delivery models | "So, what we need is a better system." |
| Evidence of demonstrating the nature of the problem - stigma and the deficiencies of current models of practice. | "...there is a real gap in terms of services - shortage of services but also once they leave Early Intervention, yet the expectations increase when they move more into the community." |
| Evidence of commitment to change                                           | "Most of us are now moving away from traditional therapy to more collaborative approaches."
<p>| Evidence of insight into the need for psychological housing, including the need for creative, relational, and emotional environments of services. | &quot;So there was all the emphasis on &quot;empathy.&quot; |
| Evidence of internalisation of information                                 | &quot;Those are the things that we need to be able to emphasise here and we need to work across different ideas and whenever we can adopt it here.&quot; |
| Evidence of impact effect regarding the improvement of slopes in terms of. | &quot;So at hand I was very keen to get a slope for the most pertinent part of the analysis for effectiveness.&quot; |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Example of statement</th>
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</thead>
<tbody>
<tr>
<td>Evidence of openness for new ideas/ alternative strategies and models.</td>
<td>“Looking at other services interstate and using that to set up our service for the future.”</td>
</tr>
<tr>
<td>Evidence of critical reflection regarding models.</td>
<td>“I am getting much better results/outcomes than a few years ago under other models.”</td>
</tr>
<tr>
<td>Evidence of identification of the need for change in current service delivery models.</td>
<td>“So, what we need is a better system.”</td>
</tr>
<tr>
<td>Evidence of understanding the nature of the problem - insight into the deficiencies of current models of practice.</td>
<td>“…there is a real gap in terms of services – shortage of services for kids once they leave Early Intervention, yet the expectations increase when they move more into the community.”</td>
</tr>
<tr>
<td>Evidence of commitment to change.</td>
<td>“Most of us are now moving more away from direct therapy to more collaborative approaches.”</td>
</tr>
<tr>
<td>Evidence of insight into the need for strategical planning, including the need to analyse external and internal environments of services.</td>
<td>“So there was all this external stuff going on...”</td>
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<tr>
<td>Evidence of internalisation of information presented in focus groups.</td>
<td>“Those are the things we think we will be able to implement here and we are still working through the ideas and whether we can adopt it here.”</td>
</tr>
<tr>
<td>Actions taken / effort regarding the implementation of changes in terms of:</td>
<td>“So at least I was very keen to get at least the timetabling part of it underway for all of us.”</td>
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<tr>
<td>Workforce development or changes.</td>
<td></td>
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<tr>
<td>Organisational and/or procedural development or changes.</td>
<td></td>
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<tr>
<td>Resource allocation or applied for funding to implement changes: financial, equipment, workspace.</td>
<td></td>
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<tr>
<td>Development of partnerships and networks.</td>
<td>“We are just going to take parts of it.”</td>
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<tr>
<td>Evidence of:</td>
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<tr>
<td>a synthesis of old and new views, that is the use of certain new concepts of a different model combined with current practice.</td>
<td></td>
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<tr>
<td>a decision made to negate current views regarding current service delivery models and moving onto a different model.</td>
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<tr>
<td>Service Delivery Model</td>
<td>Number of references</td>
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</tbody>
</table>
| Early intervention, promotion and client education | 7.5 | 3 | "It was important to me... just like we were doing... running the problems over and over again at what the problem was, and working on early services..."
| | | | but we need to be more into engaging parents more in the early services so that they will feel more of the things at home as well..."
| Client / family-centred services | 5 | 2 | "Rural practice is still giving families the choice: the opportunity to learn what they want, that they can have the whole child and learning...it's a realistic outcome for them. Kinship families is...it's not just a court ordered and written outcome..."
| Use of support staff, multi-disciplinary and person-centred intervention | 4 | 1 | "But I do believe, generally, that having parents and teachers in those settings and knowing the intervention in which the children are learning...it adds more evidence..."
| One to one, direct service delivery | 3 | 1 | "We are vacationed to conduct...there is a place for it...we get success. Some parents want...it's a..."
| Health promotion | 3 | 4 | "We need more...to the primary health care..."
| Intervention in community environmental | 3 | 3 | "In order to...the setting of learning...as an environment...it's hard to...to build those...to realise the environment..."
<table>
<thead>
<tr>
<th>Service Delivery Model</th>
<th>Number of references</th>
<th>Rating according to prevalence</th>
<th>Relevant statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention, prevention and client education</td>
<td>7</td>
<td>1</td>
<td>“It’s very important to invest now – Early Identification … turning the problems over and looking at what the reasons are, and providing an early service.”; “…but we need to be more into engaging parents more in therapy sessions so that they will go home and do things at home as well.”</td>
</tr>
<tr>
<td>Client / family centred services</td>
<td>5</td>
<td>2</td>
<td>“Best practice is about giving families the choice… the opportunity to learn what they want… what they can have for their children and learning what is a realistic outcome for them. Enables families to take much more control and noticing successes.”</td>
</tr>
<tr>
<td>Use of support staff, multi-skilling and personnel substitution</td>
<td>4</td>
<td>3</td>
<td>“But I do believe, generally, that having parents and teachers in those settings and environments in which the children are learning, to provide the therapy themselves…”</td>
</tr>
<tr>
<td>One to one, direct service delivery</td>
<td>3</td>
<td>4</td>
<td>“We are committed to hands-on; there is a place for it. We get success. Some parents want that one to one – it is more intensive.”</td>
</tr>
<tr>
<td>Comments: Two of these services indicated that one to one, direct intervention needs to be seen within the context of delivery in combination with other models. One mentioned that limited financial and human resources makes one to one treatment ineffective. The third indicated that they were committed to providing one to one direct services – it provided more intensive intervention.</td>
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<tr>
<td>Health promotion</td>
<td>3</td>
<td>4</td>
<td>“Moving more to the Primary Health Care.”</td>
</tr>
<tr>
<td>Intervention in functional environments</td>
<td>3</td>
<td>4</td>
<td>“To get that transfer of learning to other environments… not have intervention in isolation… do intervention in realistic environments.”</td>
</tr>
<tr>
<td>Service Delivery Model</td>
<td>Number of references</td>
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<td>Relevant Statements</td>
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<tr>
<td>The community based approach</td>
<td>3</td>
<td>4</td>
<td>“I strongly believe that best practice is relevant to individual communities…”</td>
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<td></td>
<td></td>
<td></td>
<td>“…communities being supportive of families and children and making families feel it is not only their responsibility, but that the community has a responsibility as well… Feel connected to community.”</td>
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<td></td>
<td></td>
<td></td>
<td>“But I do believe, in generally, that having parents and teachers in those settings and environments in which the children are learning… to provide the therapy themselves…building in supports in any community… if they have got access to supports, because that’s were children learn.”</td>
</tr>
<tr>
<td>Groups</td>
<td>2</td>
<td>5</td>
<td>“Groups…to be time efficient within limited resources. Groups are still a good way of delivering services…”</td>
</tr>
<tr>
<td>Collaborative consultation</td>
<td>2</td>
<td>5</td>
<td>“We need to use our consultative skills more rather than seeing ourselves as “therapists”. Stepping back a bit and being more of an educator – letting them do more of the work.”</td>
</tr>
<tr>
<td>Centre based services</td>
<td>1</td>
<td>6</td>
<td>“…because parents benefit from social integration. Also for therapists.”</td>
</tr>
<tr>
<td>Trans-disciplinary teamwork</td>
<td>1</td>
<td>6</td>
<td>“… using the Trans-disciplinary Approach.”</td>
</tr>
<tr>
<td>Interagency collaboration</td>
<td>1</td>
<td>6</td>
<td>“It would be good if there is more collaboration of services among agencies – come to some sort of agreement…”</td>
</tr>
<tr>
<td>Case management</td>
<td>0</td>
<td>7</td>
<td>N/a</td>
</tr>
</tbody>
</table>