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TOWARDS FACILITATING CHANGE IN OCCUPATIONAL THERAPY MANAGERS' PERCEPTIONS OF EARLY INTERVENTION SERVICE DELIVERY IN SOUTH AUSTRALIA

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ABSTRACT

Occupational therapy service delivery within the field of early intervention in South Australia is going through change and development. Services find themselves within a continually evolving environment that requires flexibility in being able to meet the changing needs of society. International trends in the field of early intervention service delivery are towards the use of early detection and prevention strategies; the involvement of both the client and the family in service delivery; client centeredness and client education, as well as the recognition of the value of direct, client-focused intervention. Team-based approaches are used in order to provide a holistic service, as are working with key people in the child's life, and networking with other organisations. The trend is towards integrating the child and family into the community and recognising contextual factors in child development.

In South Australia, several developments indicate that health care and other government policies support early intervention services, but it seems that problematic factors have impacted on the implementation in occupational therapy. These developments, together with geographically-specific sociological, demographical and professional factors underlie the changes that are currently occurring in services within this field.

The foundation for facilitating change within services is the facilitation of internal processes of change within individuals. It is within this context that this project was implemented to facilitate change in the perceptions of occupational therapy managers regarding service delivery within the field of early intervention. Fourteen occupational therapy managers of early intervention services participated in the study. A multi-phased, naturalistic design with aspects of a participatory action research approach, as well as the structure of a pre-post test design, was utilised. Complementary data derived from the use of a number of research tools was obtained over a period of six months. Online focus groups provided a forum for exposure to a variety of service delivery models by means of a change-orientated program. Pre- and post intervention questionnaires measured the perceptions of

managers both before and after the change-orientated program, and the follow-up interviews provided longer-term indicators of changes in perceptions.

The project provided valuable information on managers' perceptions of the processes of change that are occurring in service delivery. It provided a description of current service delivery models and the difficulties experienced in facilitating change from managers' perspectives. The change-orientated program utilised in this research project proved to be appropriate in facilitating critical reflection on current practice. Results and findings indicate that managers' perceptions regarding changes in practice are generally in line with international trends. Findings suggest that the characteristics of occupational therapy managers and services are such that they are well equipped to facilitate change. Some managerial and organisation-specific characteristics that may inhibit processes of change were identified and have resulted in recommendations being made for early intervention practice. The study provided an early attempt at identifying a framework of standards for practice for the development of new models of service delivery. In addition, the study provided information on the utilisation of online focus groups as a research medium. Overall, this study has contributed to an improved understanding of managers' perceptions of the processes of change that occur in practice, with subsequent recommendations being made for future practice and research.

Keywords: Occupational Therapy, Paediatric Services, Early Intervention, Models of Service Delivery, Change, Questionnaire, Online Focus Groups, Interviews.

ABSTRAK

Arbeidsterapie dienste in die veld van vroeë intervensie in Suid-Australië is in die proses van verandering and ontwikkeling. Dienste bevind hulself in 'n gedurig veranderende klimaat wat buigbaarheid vereis om aan te pas by die veranderende behoeftes van die samelewing. Internasionale tendense in die veld van vroeë intervensie sluit in strategieë verwant aan vroeë identifisering en voorkoming; die betrokkenheid van die kliënt en familie; kliënt-gesentreerde dienslewering en kliënt-opvoeding, sowel as erkenning vir die waarde van direkte, kliënt-gefokusde intervensie. Span benaderings word gebruik om 'n holistiese diens te lewer, tesame met samewerking met ander sleutelpersone in die kind se lewe asook met ander dienste. Die tendens is om die kind en familie te integreer in die samelewing en erkenning te gee aan die kontekstuele faktore wat 'n rol speel in kinderontwikkeling.

Ontwikkelings in Suid-Australië dui aan dat ofskoon die gesondheidstelsel en die regering se beleid vroeë intervensie ondersteun, dit tog blyk dat problematiese aspekte die implementering daarvan in arbeidsterapie beïnvloed. Hierdie ontwikkelings, tesame met geografies-spesifieke sosiale, demografiese en professionele faktore, onderlê die veranderings wat tans plaasvind in die dienste in hierdie veld.

'n Fondasie vir die fasilitering van verandering in dienste is die fasilitering van interne prosesse van veranderings in individue. Dit is in hierdie konteks dat hierdie projek geïmplementeer is om verandering te fasiliteer in die sienings van arbeidsterapiebestuurders in verband met dienslewering in die veld van vroeë intervensie. Veertien bestuurders van arbeidsterapie dienste in vroeë intervensie het aan die studie deelgeneem. 'n Multi-fase naturalistiese ontwerp is gebruik met aspekte van 'n deelnemende aksie navorsing benadering, sowel as die struktuur van 'n pre-post toets ontwerp. Aanvullende data in verband met die gebruik van 'n aantal navorsingsinstrumente is oor 'n tydperk van 6 maande versamel. Fokusgroepe wat aanlyn aangebied is, het 'n forum gebied vir die blootstelling van

bestuurders aan 'n aantal diensleweringsmodelle. 'n Pre-en post intervensie vraelys is gebruik om die sienings van bestuurders te bepaal voor en na interaksie in die fokusgroepe. Die opvolgonderhoude het gefokus op langer termyn veranderings in persepsies.

Die projek het waardevolle inligting gebied rakende bestuurders se persepsies oor die proses van verandering wat in die lewering van dienste plaasvind. Dit bied 'n beskrywing van die diensleweringsmodelle wat tans gebruik word en die problematiese aspekte wat ondervind word. Die intervensie program was toepaslik in die fasilitering van kritiese refleksie op bestaande praktyk. Die resultate en bevindings dui daarop dat die persepsies van bestuurders rakende veranderings in praktyk, in die algemeen in lyn is met internasionale tendense. Bevindings dui aan dat bestuurders en dienste se eienskappe sodanig is dat hulle goed toegerus is om veranderings teweeg te bring. Bestuurs- en organisasie-spesifieke eienskappe is geïdentifiseer wat die veranderingsprosesse inhibeer en hierdie bevindings het aanleiding gegee tot aanbevelings vir die praktyk. Die studie het 'n vroeë poging gebied in die identifisering van standaarde vir praktyk vir die ontwikkeling van nuwe modelle van dienslewering. Hierdie studie het ook inligting rakende die aanwending van aanlyn fokusgroepe as navorsingsmedium gebied. Hierdie studie het, in opsomming, bygedra tot 'n verbeterde insig in bestuurders se persepsies van die prosesse van verandering wat in die praktyk plaasvind en daarvolgens is aanbevelings vir die praktyk en toekomstige navorsing gemaak.

Sleutelwoorde: Arbeidsterapie, Pediatrie, Vroeë Intervensie, Diensleweringsmodelle, Verandering, Vraelys, Aanlyn Fokusgroepe, Onderhoude

DECLARATION

I declare that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma at any university; and that to the best of my knowledge, it does not contain any material previously published or written by another person, except where due reference is made in the text.

Kobie Boshoff

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1 INTRODUCTION

1.1 INTRODUCTION TO THE STUDY AND MAIN CONCEPTS

A considerable body of literature exists with references relating to the continually changing environments of organisations of our era. The occupational therapy profession is not immune to this changing environment in the delivery of services to its client groups. In order to ensure the appropriateness of service delivery, it is essential to keep track of these changes, analyse them carefully, and plan accordingly (Shakleton & Gage, 1995). For its survival, occupational therapy may very well be dependent on its ability to act quickly and effectively in response to changing needs, as stated by Cromwell (1984). Poulden and Oke (1990) also emphasise the need of the profession to be pro-active and plan accordingly, and state that by being pro-active, occupational therapists will ensure that they continue to play valued, ongoing roles amidst ongoing changes.

Due to the dynamic environment in which services are delivered, service delivery models are continually evolving (Vestal, 1995) and therapists therefore have to continually reflect on principles for best practice (Dunn, 2000). Dunn warns against the continuation of traditional practices purely because services have always been delivered in a particular way. She calls on therapists to be creative and innovative, while basing their practices on current knowledge and evidence.

One of the fields that is characterised by continual changes, is the field of early intervention. This specialised field refers to intervention at an early stage in the life of the child. It is a field shared by a number of professions that may all have different intervention approaches. Occupational therapists working within this field in South Australia are currently experiencing pressures to meet the demands of both the environment and their client groups in terms of the continual provision of high-quality as well as appropriate services. Although early intervention is supported by government policy as a service priority, several factors make its implementation problematic. In the development of appropriate services, the

literature provides therapists with international trends in early intervention service delivery that may serve as a framework for considering new developments.

It is within this context that this project, which aims to investigate the changes occurring in the field of early intervention in South Australia, was undertaken. For the purposes of this study, early intervention is defined as the paediatric intervention services provided by occupational therapists. The term "paediatric" is used due to the developments that are still occurring within the broader field of paediatric service delivery, and the accompanying undefined age and population groups currently being serviced within the field of early intervention. The project attempts to capture participants' perceptions regarding early intervention service delivery both before and after exposure to a program orientated towards facilitating change.

Managers of early intervention services in occupational therapy were selected as participants based on the critical roles they play in facilitating change in organisations as problem solvers and change agents. In addition, managers play a coordinating role and are valuable sources of information regarding service delivery. For the purposes of this study, occupational therapy managers are considered to be occupational therapists in senior capacities who deal with the provision of services to children. Managers participated in a change-orientated program, not only to provide them with an opportunity to acquire information, but also for internal personal processes of change to occur. These aspects form the basis for change and may result in the implementation of organisational change.

1.2 OUTLINE OF CHAPTERS

The chapters that follow provide an in-depth description of particular aspects of the study: Chapters 2 and 3 provide the literature background for the study, with Chapter 2 focusing on current practice and challenges in the field of early intervention service delivery. Chapter 3 discusses the facilitation of change in service delivery and the basis of a program aimed at facilitating change. In Chapter 4, the research design and methodology are provided.

Chapter 5 provides a discussion on the results and findings of the study. The discussion is concluded in Chapter 6 with an evaluation of the study and recommendations for future practice and research.

1.3 ABBREVIATIONS USED

A limited number of abbreviations are used throughout this thesis, with some occurring in direct quotes from participants. The definitions of the abbreviations are: Occupational Therapy (OT); Occupational Therapists (OTs); Early Intervention (EI); Focus Group (FG).

1.4 SUMMARY OF CHAPTER

This chapter provides a brief overview of the main elements of the study and the discussions that follow in the next chapters. Chapter 2 consequently provides a detailed layout of the current trends and practices in early intervention as the basis for this study.

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2 EARLY INTERVENTION SERVICE DELIVERY: CURRENT PRACTICE AND CHALLENGES

Chapter 2 sets the scene for understanding both the international and the South Australian contexts of early intervention service delivery. It describes the concepts of early intervention, the contexts and current trends in service delivery, and the current challenges faced by occupational therapists who work in this field in South Australia.

2.1 DEFINING THE CONCEPT OF EARLY INTERVENTION

Early intervention is a field of intervention shared by a number of professionals who have a common belief in the value of intervention at any early stage in the life of the child. These professionals believe in the early identification of disorders and early intervention to maximise the impact of intervention on the child's life and prevent further progression of disorders. The mission of early intervention is to assist young children and families to thrive (Shonkoff & Meisels, 2000).

Within this shared underlying general philosophy and mission, the term "early intervention" has different meanings for the different parties involved in service delivery. The age range for entry into early intervention services is one of the aspects that varies significantly between services. For example, Shonkoff and Meisels (1990), recognised as leaders in the early intervention field, define the age group as birth to three years, while other programs with variable ages include, for example, the Child and Family Resource Program in the USA with its population defined as birth to eight years (Zigler, 2000), the Collaborative Perinatal Project – birth to seven years (Broman, Bien & Shaughnessy, 1985), and the AusEinet project, which covers the ages from birth to 24 years (The Australian Early Intervention Network for Mental Health in Young People, 2000). The age group for early intervention in South Australia is defined as birth to 6 years (Department of Human Services, 1999). In practice, the term "Early Childhood Intervention" generally refers to services for children up to the age of formal school entry. In addition to the variances in ages, variances in

types of population groups also occur, for example services that prioritise children at risk, as is the case in Britain, or in contrast, Europe, Japan and Korea, where all children are targeted (Shonkoff & Meisels, 2000).

The definition of the type of service under the broad banner of early intervention also varies significantly, due to the different perspectives that each professional discipline brings to the field. International literature provides various examples of programs that have a specific focus. Examples are provided by Shonkoff and Meisels (1990): psychodynamic and developmental perspectives (Greenspan, 1990); behavioural-ecological approaches (Vincent, Salisbury, Strain, McCormick & Tessier, 1990), and neurobiological models (Anastasiow, 1990), amongst others. The focus of intervention varies according to the composition of the early intervention teams involved, and the specific population groups serviced. In some countries, such as Australia, early intervention services consist of mainly health care professionals, while others also include representatives from the education and other sectors, as recommended by pioneers of educational programs such as Sequin and Montessori (Shonkoff & Meisels, 2000). Others take a broader view in incorporating government agencies and government-supported programs, such as child care facilities; agencies that provide financial contributions to parents, assist with housing and standards of living / living conditions, and also those dealing with legislation and employment conditions for parents, as is the case in Europe (Shonkoff & Meisels, 2000). Others incorporate families' local communities, for example community centres, toy libraries, sporting facilities and support services for various population groups, such as services for multi-cultural and single-parent populations in the USA (Peck, 1993).

Adding to the complexity of defining the field of early intervention, are the considerable changes that this field has undergone during the past 40 years. Although the general philosophy of early intervention has remained the same, different trends have come and gone as the field has struggled to provide scientific evidence of its effectiveness and the

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most effective way of achieving outcomes for children. The aforementioned difficulties in defining the field of early intervention, have all contributed to the difficulty of establishing a sound scientific basis for the field. In addition, difficulties in research practicalities have resulted in added complications and, in some cases, a lack of credibility in terms of existing studies. For example, the ethical considerations are considerable when comparing a group who is receiving intervention, while another group is being withheld from intervention in order to serve as a control group. The longitudinal nature of early intervention outcomes calls for long-term studies, which require time and ongoing, adequate funding over a number of years. Various uncontrollable factors also influence intervention outcomes, one of which is the quality of service delivery, which may, once again, influence the scientific credibility of studies if these factors are not addressed properly.

In spite of these difficulties in grounding the scientific basis of early intervention, clinicians, parents, school personnel, and other parties involved in this field, have continued to lobby for these services, based on their underlying belief in the efficacy of early intervention, as well as the economic benefits of early intervention (Barnett & Escobar, 1990). This has resulted in developments in early intervention internationally, with the current renewed focus on the value of early intervention in contributing to the lives of children worldwide.

2.2 INTERNATIONAL INFLUENCES AND DEVELOPMENTS IN THE FIELD OF EARLY INTERVENTION

European countries and the USA are described in the literature as leaders in the field of early intervention. Both provide different perspectives to the field. Table 1 summarises the major international influences and developments in the field. When reading Table 1, the overlaps that exist between the different influences and developments should also be considered.

In Europe, some countries view early intervention not as a separate service delivery system, but as part of a broad network of government-supported programs. Countries such as Denmark, France, Finland and Sweden provide a comprehensive family support "package" that may consist of high-quality and accessible child care services, financial support for families, paid parental leave, and other support programs. These programs have been initiated mainly through political support rather than research evidence of the effectiveness of such measures. Europe draws on many of the research foundations that are being developed in the USA to underpin its programs (Kamerman, 2000).

Table 1 International Influences and Developments in the Early Intervention Field

Origin of Developments and Influences	Developments in Early Intervention Service Delivery	Main Influences
Europe	Broad network of programs. Comprehensive package of services.	Political lobbying and support.
USA	Assimilation of information on projects identified as resulting in favourable outcomes for clients. Agreement regarding the field's efficacy.	Occupation with pursuing scientific evidence of the field's efficacy, together with advances in research methodologies and medical technology.
Nature versus Nurture Debate	Recognition of both biological and environmental factors on child development. Improved understanding of biological processes in brain development with resultant improved intervention strategies. Acknowledgment of impact of environment on child development resulting in the following trends: Social inclusion, family centred practice, client empowerment, cultural sensitivity, and coordinated service delivery.	Refinement of research methodologies. Advances in medical technology. Advances in studies on brain development.

Currently, the USA is at the forefront of contemporary research and it has proved to be an international leader whose research and policies impact on the policies of many other countries. Since the inception of the early intervention field in the early 1960s, programs have undergone revolutionary developments. A plethora of literature exists which documents the history of early intervention programs in the USA. Based on clinicians' experiences of the impact of early intervention on the life of the child, the field has occupied itself with proving

its efficacy in order to strengthen the scientific base and therefore the commitment of the government and others for early intervention programs. The body of literature is overwhelming with, until recently, inconsistent results regarding the efficacy of programs. For example, Ryan (1974) provides a discussion in the Report on Longitudinal Evaluations of Preschool Programs, which includes the earlier evaluations of the Head Start program.

The Head Start program is one of the earliest early intervention initiatives that is worth mentioning. The Head Start program is a national program that commenced in 1965 and has been a key government initiative in the field of early intervention. Its initial conceptual framework was revolutionary for its time, with its focus on community and family participation, in conjunction with child development (Peters & Kontos, 1987), the involvement of a broad array of professionals, and its combination of health, education and social services (Shonkoff & Meisels, 2000). Since its inception, it has overcome many hurdles and modifications. An assessment has been due in 2000-2001. Another project – the Collaborative Perinatal Project, has provided the most extensive longitudinal data on the impact of biological and social risk factors (Shonkoff & Meisels, 2000; Broman, Bien & Shaugnessy, 1985). This project influenced the debate of "Nature versus Nurture", a debate that has been ongoing since the field was initially established. Some dialogue regarding this issue may still be found in the literature to this day.

The "Nature versus Nurture" debate contributed to the questioning of the value of early intervention on a child's development. Early pioneers in the field, such as Gesell in the early 1900s, believed in the genetic predisposition of the developmental progression in the child, while others, such as Hunt (1961) and Broman, and Nichols and Kennedy (1975), were convinced of the impact of environmental forces on developmental outcomes. Various projects were launched as a result of this controversy, and led to government support of research projects and services during this period. Since then the early intervention field has come to the realisation that both these factors (developmental and environmental) influence

child development interactively. The longitudinal assessment of the Collaborative Perinatal Project indicates support for the impact of biological and social risk factors on development (Broman, Bien & Shaughnessy, 1985). In addition, the National Research Council and Institute of Medicine (Shonkoff & Phillips, 2000), which consolidates the research in early intervention, supports the recognition of both influences.

The 1980s and 1990s saw an evolution in the concepts of social inclusion, family-centred practice and empowerment, cultural sensitivity, and coordinated service delivery in early intervention (Halpern, 2000). The field of early intervention saw the refinement of research methodologies in an endeavour to develop more scientifically sound studies, and the 1990s saw breakthroughs in the examination of brain development (Shonkoff & Meisels, 2000). With the increased acknowledgement of the impact of the environment on child development, research during several of the past decades has focused on an expanded understanding of the conditions that influence child development (National Research Council and Institute of Medicine, 2000).

During the past decade, the field of early intervention has started to assimilate scientifically sound studies to provide evidence of its efficacy, as well as evidence regarding the development of the brain and its receptiveness for intervention during the early years of life. These studies are documented in publications of various leaders in the field, such as the Carnegie Corporation of New York (1994), Broman, Bien and Shaughnessy (1985), and Lipsey and Wilson (1993) – with the latter two authors conducting a meta-analysis of early intervention projects. In addition, Guralnick (1997), Shonkoff and Meisels (2000), and the National Research Council and Institute of Medicine (2000) have assimilated projects that have resulted in favourable outcomes. Common themes may be identified amongst these selected, well-designed studies, as well as a general agreement regarding the field's efficacy. Advances in scientific, rigorous research methodologies and medical technology have also contributed to these results.

In relation to the future of the field of early intervention, leaders are urging researchers and practitioners to focus on identifying program characteristics that facilitate favourable development outcomes for children (Lipsey & Wilson, 1993), and also to formulate well-grounded standards of practice (Shonkoff & Meisels, 2000). It is within this call for investigating standards of practice that this discussion will now focus on a consolidation of literature regarding international trends in the field of service delivery and current perceptions regarding standards of practice.

2.3 INTERNATIONAL TRENDS IN EARLY INTERVENTION SERVICE DELIVERY

Modern trends in service delivery may be identified in the literature. A number of recent publications report on projects that aim at identifying program characteristics that have resulted in favourable development outcomes for children. In addition, other publications provide information on approaches that are based on the consensus of experienced interventionists. Examples of these include Shonkoff and Meisels (2000), and Guralnick (1997). The trend towards working more collaboratively is implicitly interwoven in these programs and may be categorised as follows: collaboration with the client, collaboration with the community, collaboration with other team members, and collaboration with other agencies and program characteristics. Table 2 depicts these current trends in early intervention and will be referred to in later chapters.

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Table 2 Current Trends in Early Intervention Service Delivery, as identified in the Literature

Current Trends in Service Delivery		Author and Date of Publication
A. COLLABORATION WITH CLIENT		
Prevention	Preventative measures.	Osofsky & Thompson (2000), Meisels (1984), Guralnick (1997).
Family-centred Practice	Family-centred practice.	Halpern (2000), Carnegie Corporation (1994), Dunn (2000), The American Occupational Therapy Association ([AOTA]1989), Winton, McCollum & Catlett (1997), Wyngaarden Krauss (2000).
	Understanding the family as a dynamic system.	Shonkoff & Meisels (2000).
	Centred on needs of the family.	Guralnick (1997).
	Family involvement and empowerment.	Simeonson & Bailey (1990), Wyngaarden Krauss (2000).
	Enabling and empowering relationships between service providers and families.	Harbin, McWilliam & Gallagher (2000).
	Family involvement as decision makers in service delivery.	Wyngaarden Krauss (2000).
	Parent education.	Halpern (1990), Simeonson & Bailey (1990), Osofsky & Thompson (2000), Carnegie Corporation (1994).
	Caregiver-focused interventions.	Seitz & Provence (1990).
	Sensitivity to families and cultures.	Harbin, McWilliam & Gallagher (2000).
	Improvement of family coping skills.	Simeonson & Bailey (1990).
	A range of family services.	Simeonson & Bailey (1990).
	Promotion of family conditions, parental competencies and behaviour.	Halpern (1990).
Child-focused Programs	Client involvement.	Dunn (2000).
	Individualisation of service delivery.	The National Research Council and Institute of Medicine (2000), Wolery (2000).
	Individualisation of targeted programs.	Sameroff & Fiese (2000).
	Child-focused programs.	Bricker & Veltman (1990).

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Table 2 Continued

Current Trends in Service Delivery		Author and Date of Publication
B. COLLABORATION WITH THE COMMUNITY		
Community-based programs	Community-based intervention.	Guralnick (1997), Halpern (2000).
	Involvement and support of local community.	Halpern (2000), Carnegie Corporation (1994).
Programs that address Contextual Influences	Focus on the relationships between parent and child.	Osofsky & Thompson (2000), Kelly & Barnard (2000).
	Facilitation of social networks and support for families.	Osofsky & Thompson (2000).
	Consideration of family and contextual influences.	Crnic & Stormshak (1997), Sameroff & Fiese (2000).
	Emphasis on the social supports of the family.	Dunst, Trivette & Jodry (1997), Osofsky & Thompson (2000).
	Promotion of child's social competence.	Guralnick & Neville (1997).
	Recognition of cultural competence.	The National Research Council and Institute of Medicine (2000), Garcia Coll & Magnuson (2000).
	Recognition of impact of relationships on development.	The National Research Council and Institute of Medicine (2000), Garbarino & Ganzel (2000).
	Recognition of impact of community, broader social, economic and political environment.	Shonkoff & Meisels (2000), Earls & Buka (2000).
	Environmental impact on development and fostering of nurturing environment.	Carnegie Corporation (1994).
Integrated, functional Intervention	Integrated into community.	Peck (1993).
	Integrated into integrated settings.	Wolery & Fleming (1993).
	Integrated into child's routine.	Dunn (2000).
	Provision of services in natural environment, including inclusive educational and childcare settings.	Gallagher (2000).
C. COLLABORATION WITH OTHER TEAM MEMBERS		
Teamwork	Integration of contributions of multi-disciplinary team members.	Guralnick (1997), Sameroff & Fiese (2000), McCune, Kalmanson, Fleck, Glazewski & Sillari (1990), AOTA (1989), Dunn (2000).
	Recognition of the inter-disciplinary nature of the field.	Shonkoff & Meisels (2000).
	Multi-, inter- and trans-disciplinary team approaches.	Dunn (2000).

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Table 2 Continued

Current Trends in Service Delivery		Author and Date of Publication
D. COLLABORATION WITH OTHER AGENCIES		
Network of Programs	A comprehensive, cohesive system.	Harbin, McWilliam & Gallagher (2000), Gallagher (2000).
	Continuous, comprehensive and integrated services.	Halpern (2000).
	A multitude of programs and resources.	Harbin, McWilliams & Gallagher (2000).
	Continuous service delivery with attention to transition between programs.	Gallagher (2000).
	The integration of childcare, early education and early intervention.	Kagan & Neuman (2000).
	Coordinated service delivery.	Shonkoff & Meisels (2000), Gilkerson, Gorsk & Panitz (1990), Dunn (2000).
	Case management to ensure coordinated services.	Harbin & McNulty (1990).
	Consultation and collaboration.	Hanson & Widerstrom (1993).
	Interagency collaboration.	AOTA (1989), Dunn (2000).
E. OTHER PROGRAM CHARACTERISTICS		
Leadership	Characteristics of leaders of programs: a clear sense of mission, a broader and more comprehensive vision of the service system, the ability to communicate vision to stakeholders, knowledgeable about best practice and utilising best practice, use of a variety of resources, adept at understanding complex situations, creating and facilitating change.	Harbin, McWilliam & Gallagher (2000).
Service Providers	Qualities of service providers: knowledgeable and use of best practice, use of initiative and resourcefulness, flexibility, and responsiveness.	Harbin, McWilliam & Gallagher (2000).
Mix of Service-delivery Models	Mix of parent support and direct developmental services.	Halpern (2000), National Research Council and Institute of Medicine (2000).
	Focus on individual client variables and contextual variables.	Dunn (2000).
	Mixed options of service delivery available to clients.	Dunn (2000), AOTA (1989).
	Direct services used only in combination with other models.	Dunn (2000).
Well-designed and Goal-focused Programs	Well designed and goal focused.	National Research Council and Institute of Medicine (2000).
	Planning and coordination of services.	Guralnick (1997).

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2.3.1 Collaboration with the Client

Some of the earliest programs in America concentrated on single-dimension, child-focused approaches during which a prescribed program of stimulation was implemented by an interventionist (Simeonson & Bailey, 2000; Osofsky & Thompson, 2000). These programs were usually implemented in isolation, for example, either at home or at a centre, by one professional, with the focus on one type of service and from one philosophical viewpoint (Harbin, McWilliam & Gallagher, 2000). Lessons learnt from this period include the effectiveness of individualised, well designed and implemented programs. The characteristics of these programs are supported in current literature as an important option in service delivery (National Research Council and Institute of Medicine, 2000).

Modern trends that may be distinguished in the literature relating to collaboration with the client, are provided in Table 2. These include, amongst others, preventative strategies and family-centred practices, which include family involvement, empowerment and parent education. Child-focused programs fall into this category as a trend carried over from earlier programs in recognising its effectiveness in terms of individualisation of service delivery and individually targeted programs, and include the trend towards client involvement in the planning of intervention, as well as during intervention itself.

Since then, programs have undergone considerable changes due to the influence of research findings on effective programs and other environmental factors impacting on the delivery of services in America. The following current and future challenges in the social and economic circumstances of families are examples of changes that impact on service delivery and that services hence need to adapt to: high levels of hardship for families, changes in parents' employment, the increase in the number of children in child care settings, and a greater awareness of the negative effects of stress on young children (National Research Council and Institute of Medicine, 2000). These factors have contributed to an increased

focus on recognising the environment as an important aspect in intervention, with increased collaboration with the community, significant others in the child's life, and other agencies.

2.3.2 Collaboration with the Community

Modern trends include the active involvement and support of the community in intervention, and the recognition of contextual influences on intervention, with the underlying principle being an acknowledgment of the impact of environmental influences on the early development of the child. It includes a focus on the integration of the family into the community; on social networks, relationships and supports, as well as families' cultural, economic and political environments. In addition to this, it recognises the provision and integration of intervention into functional environments of the child and family.

2.3.3 Collaboration with other Team Members

When viewing the child and family in a holistic way, which includes both biological and environmental factors, teamwork becomes essential. Modern trends are to work collaboratively in multi-, inter-, and trans-disciplinary teams in order to make intervention appropriate and streamlined.

2.3.4 Collaboration with other Agencies

One of the current international trends is the European influence that supports a well-integrated, coordinated and comprehensive network of services across a broad spectrum of programs. Programs that support families on multiple levels and keep pace with modern demands on them are utilised in order to effectively support them in providing a nurturing environment for their children. This view is also supported in the American literature (Harbin, McWilliam & Gallagher, 2000; National Research Council and Institute of Medicine, 2000). Case management is mentioned in the literature as a strategy to coordinate service delivery within a network of services and to ensure effective interagency collaboration.

2.3.5 Other Characteristics of the Program

The literature identifies other program characteristics that have resulted in favourable outcomes for clients: characteristics of its leadership; the service providers; the use of an appropriate mix of service delivery models, including a focus on both individual client variables and contextual variables; and well-designed, goal-focused programs. It is within this international framework of developments and trends that the discussion now turns to the South Australian context of early intervention service delivery.

2.4 THE SOUTH AUSTRALIAN CONTEXT OF EARLY INTERVENTION SERVICE DELIVERY

Early intervention service delivery in South Australia has been influenced by a number of context-specific factors, including developments in the following government areas: health care and health services for children; mental health services; and disability services. In addition, the demographical and sociological contexts of South Australia and profession-specific factors influence service delivery. These areas are summarised in Table 3 and provide a framework for the discussion that follows.

2.4.1 Government Policies and Funding Priorities

2.4.1.1 Health Care

Early intervention in South Australia has followed international trends in the adoption of a focus on primary health care and health promotion. Primary health care includes the prevention of diseases, early detection and intervention (The South Australian Health Commission, 1992). It is seen as a means of achieving health for all and focuses on inequities in health status and on equal access to health care. The principles underlying primary health care are provided in Table 3.

Managed by the Minister of Health, and the Housing and Community Services of the Commonwealth at a national level, Australia has followed the international trend by stating its

commitment to the World Health Organisation's "Health for All by the Year 2000" strategy, published in 1981. The implementation of the health promotion strategy has subsequently been refined in a number of reports and reviews.

The process of implementation and refinement is ongoing. Difficulties experienced with the implementation of the policy include inadequate funding, difficulties with communication between states and the Commonwealth, confusion regarding roles and principles, a lack of involvement of non-government stakeholders, and a lack of uniformity in establishing priorities and implementing strategies for change (O'Connor & Parker, 1995). In addition to these difficulties in implementation, the 1980s were characterised by an overriding concern about expenditure on health, making the implementation of health promotion difficult (O'Connor & Parker, 1995).

Developments in South Australia followed national trends under the governance of the local state government. Since 1976, the South Australian Health Commission has funded the health care services in South Australia. Other organisations playing significant roles in health promotion in South Australia are the Foundation of South Australia, the Health Development Foundation, and the Community Health Centres.

The most recent "Australian Health Care Agreement", covering the period 1998 – 2003, provides current funding priorities in health care, focuses on community health, and aims at a balance between individual and community health, integrated and coordinated services, evidence-based services, equitable access and cost efficiency (Brandis, 2000). Mental health priorities are preventative care, early intervention, and the promotion of the improvement of quality and efficiency of service provision. Priorities regarding hospital services are to improve the effectiveness and efficiency of services, reduce the demand for hospital services, and improve the integration of care across hospital and community settings. Another emerging theme is the need for health care providers to form collaborative relationships with clients.

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Table 3 Core Developments in the Early Intervention Service Delivery Context in South Australia

Health Care	Funding priorities	Services to Children	Mental Health Services	Disability Services
Primary health care: health promotion, early detection and intervention.	Balance between individual and community health.	Promotion of healthy, supportive environments.	Primary health care, prevention, early intervention.	Integration into community life.
Access to services, full participation of clients, cost effectiveness.	Evidence-based practice.	Involvement of government and community.	De-institutionalisation, integration into community life.	Quality assurance.
Equity, social justice, intersectoral collaboration of all parties involved, community participation, empowerment, supportive environments, access to information, enhancing life skills and opportunities to make healthy choices.	Cost efficiency.	Customer focus.	Continuity of care.	Coordinated service delivery.
	Integrated and coordinated services.			
	Collaborative relationships with clients.			
Use of social networks.	Effectiveness and efficiency of services.	Commitment to client participation.	Relevant and high quality services.	
Client education.		Balance between health promotion and treatment of ill health.	Collaboration of services.	
		Equity and access.	Active participation of clients.	
		Coordination and collaboration between services.	Client education.	
		Development of a skilled workforce.		
		Early intervention.		

IMPACT ON EARLY INTERVENTION SERVICE DELIVERY IN SOUTH AUSTRALIA

Demographical Factors	Sociological Factors	Profession-specific Factors
Geographical layout – vast regional areas.	Changes in traditional family structures.	Client-centred intervention.
Current funding focus on health services to regional areas.	Greater diversity in childcare and increased number of children in childcare.	Evidence-based practice.
Shortage of health services and personnel in regional areas.	Changing patterns of leisure for families.	The use of team structures.
Increasing number of people with disabilities.	Increased interpersonal violence.	Staffing considerations.
	Increased integration into mainstream services.	
	Multi-cultural diversity.	
	Clients becoming more empowered and involved in service delivery.	

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2.4.1.2 Services to Children

Contributions to the development of services for children include the "Health Goals and Targets for Australian Children and Youth" (Jolly, 1992) and in 1995, the Australian Health Minister's endorsement of the "Health of Young Australians" report, which lays the foundation for the principles provided in Table 3. This report was followed by "The National Health Plan for Young Australians" (Australian Ministers' Advisory Council, 1996) that addressed the above-mentioned key areas in more detail.

The South Australian Child Health Policy and Youth Health Policy are both based on the principles of primary health care and emphasise health prevention and promotion. True to the aims of primary health care, early intervention has been an area of focus in South Australia. The Department of Human Services' Strategic Plan, entitled "The Development of a Service and Funding Plan for Children with Additional Needs", was introduced in 1998.

In 1999, the advisory group set up by the Department of Human Services reported on the early intervention services in South Australia (Department of Human Services, 1999). The report supports early identification, referral and access to services, a coordinated approach, information to be provided to health professionals and families regarding early intervention, alternative service responses and increased or better utilised resources. It calls for adequate funding of early intervention services.

The advisory group identified the early intervention target population as being children from birth to school entry (0-6 years) who have, or are at risk of, a delay in development or disability, and their families and caregivers. The report describes the nature of early intervention services by stating that various agencies may be involved in the delivery of these services. The services are provided by the State Government through the Department of Human Services, including the Disability Service Offices, the Department of Family and

Community Services, the Department of Education, Training and Employment (DETE), and various non-government agencies and parent / community groups.

Screening and assessment services are usually provided by Child and Youth Health and Child Development Units of the Women's and Children's Hospital, Flinders Medical Centre, the Llyell McEwin Health Service, and associated country services. In addition, the Early Childhood Intervention Network, funded by Child and Youth Health, the Intellectual Disabilities Council (IDSC), and DETE, have coordinators who provide information and link families to a range of services. Children identified with development delays or disabilities are referred to either the IDSC or the Crippled Children's Association (CCA). These organisations provide specialist services to families. Other services include the Autism Association, the Down's Syndrome Society, and Townsend House. Child and Adolescent Mental Health Services provide services to children under six with extreme mental health problems. In 1999, the following programs were identified as providing early intervention services: Southern Fleurieu Health Services, Port Lincoln Community Health Services, Noarlunga Community Health Services, IDSC Early Childhood Services, Kent Town Pre-School, and the Northern Regional Paediatric Unit, based at Port Augusta Hospital (Department of Human Services, 1999).

2.4.1.3 Mental Health Services

A significant development regarding mental health services in South Australia has been the adoption of the National Mental Health Policy. It was developed in 1992 as a National Mental Health Plan and committed itself to improving the lives of people with mental illness. Specific strategies were outlined (Lloyd, Kanowski & Samra, 1998). In addition, the "Prevention in Mental Health" report of the Mental Health Committee of the National Health and Medical Research Council was released (Martin & Davis, 1995). Service delivery trends and priorities are provided in Table 3. Difficulties with the funding of community-based services and resources, and limited coordination of services have since

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proved to be major obstacles. The "Action Plan for Reform of Mental Health Services 2000–2005" (Department of Human Services: Mental Health Services, 2001) that followed, embraced an effective primary health care strategy, and emphasised, amongst other things, early intervention, prevention, detection and screening, evidence-based practice and effective education about mental illness.

The Action Plan was based on the National Survey of Mental Health and Wellbeing, which aimed at obtaining information regarding the prevalence and distribution of mental health problems, the degree of disability associated with this, and specific information regarding services used by children, adolescents and families (Woolbridge, 2000). Noteworthy is the finding that children aged 6 to 12 years were more likely to have a disorder than were adolescents aged 13 to 17 years. The report states that only 50% of young people who met the criteria for a mental health illness and who indicated a need for help, actually received professional help.

2.4.1.4 Disability Services

An important new direction in the area of disability services was taken with the implementation of the Disability Services Act in 1986, which established a framework to redirect disability services, and specified the need to develop specific guidelines. The focus fell on de-institutionalisation of segregated services, and integration into community life. A lack of coordination and the abscence of an overall plan caused difficulties in implementing the policy. The "Working Solution" report reviewed the Commonwealth Disabilities Services Program in 1995 and made suggestions on the refinement of the program (Baume & Kay, 1995). This report laid the foundations for a quality assurance strategy, coordinated services, and the promotion of best practice and quality services.

South Australia showed its commitment to facilitate the integration of people with disabilities into community life by means of the South Australian Disability Services Act of

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1993 and the report entitled "Promoting Independence: Disability Action Plans for South Australia: a policy statement on the adoption of disability action plans by the Government of South Australia" (Department of Human Services, 2000).

2.4.2 Demographical Factors in South Australia

In addition to the development of a policy related to early intervention, demographical factors in South Australia also play an important role in this regard. These include changes in population growth, the geographical layout of the population, and the development of a multi-cultural society. The 1996 ABS Census estimated the total population of South Australia at 1,474,389. Its capital, Adelaide, has a population of 1 million people. Geographically, South Australia covers 984,160.2 square kilometres (Rural Health Training Unit, 2000). Apart from Adelaide, there are only two other cities, namely Whyalla and Mt Gambier, with populations of more than 20,000 people (Gay, Herriot & May, 1995).

Statistical sources such as the Australian Institute of Health and Welfare (1998), the South Australian Health Association, and the South Australian Health Commission (1992) indicate that the number of people with disabilities is increasing due to the improvements in services to this population group. In 1993, the prevalence of disability was estimated to be 70 per 1 000 children aged 0–14. Children in the 5 to 9 age group had the highest rates of disability, handicap and profound or severe handicap (Moon, Rahman & Bhatia, 1998) amongst children.

Looking at the demographics of South Australia, the increased focus on services and funding for rural and remote areas in South Australia is significant. The highest population density in South Australia is recorded in urban and coastal areas: 27% of the people live in remote and rural areas, while 73% live in Adelaide. Gay, Herriot and May (1995) describe South Australia's country areas as being characterised by a large number of small towns, separated by vast distances and experiencing considerable isolation and diversity in social

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status. This rural and remote population is served by more than 100 health care units, provided by a mixture of public, private and non-government services in 75 different locations (Gay et al., 1995). They include hospitals, community health, domiciliary care and aged care services, general practitioners, medical specialists and allied health services.

In the past, country health care has been characterised by limited health promotion and community development programs; limited services for certain population groups and those with special health needs, e.g. people with disabilities, Aboriginal people, and the elderly, and a lack of coordination between services (Gay et al., 1995). Key developments have been the National Rural Health Strategy (Department of Human Services and Health, 1994) and the report of the South Australian Health Commission (Department of Human Services), entitled "Healthy Horizons Report (2000)". Regionalisation occurred in July 1996, aiming to tailor the needs of health care services, to facilitate service planning, to further coordination and integration of service delivery, and to promote administrative efficiency (Rural Health Training Unit, 2000). Currently the provision of equitable access to adequate and appropriate health care services in rural and remote areas is a priority for the public health system (Rural Health Training Unit, 2000). The Report of the Inquiry into Infrastructure and the Development of Australia's Regional Areas, released in 2000, emphasises the shortage of health care services and personnel. The report recommends incentives to attract medical and allied health care personnel to regional areas and support services to this population as a high priority.

In addition, Australian health care literature refers to some strategies that have been trialled to facilitate access to services in rural and remote areas. Tele-Rehab is mentioned as an option by Anastassiadis, Finch, Killington and Rolan (1998), and Langley, McNair, Bray, Fletcher, Maffett and Rawicki (1998). These authors discuss the use of video conferencing to provide services to geographically and demographically isolated areas. Symington (1998) also reports on the use of a consultancy service to remote areas, in collaboration with available

local support. This consultancy service consists of on-site assessments and training, educational seminars, and an advisory telephone service.

2.4.3 Sociological Factors in South Australia

Several sociological factors in South Australia are significant and noteworthy. The "Health of Young Australians" report, endorsed by the Australian Health Ministers (1995) acknowledges the influence of the sociological factors displayed in Table 3. In addition, cultural developments also play a significant role. The report mentions the changes in multi-cultural diversity in delivering services to young Australians, and this is also mentioned in the "Action Plan for Reform in Mental Health Services 2000–2005" (Department of Human Services, 2001).

Multicultural diversity has become part of life in Adelaide to a large extent. In the period between 1950 and 1970 a high level of migration from Europe occurred. Although the dominant culture remained Anglo-Saxon, the 1980s saw an increase in other cultural influences. The report entitled "Developing Accessible Services for People with a Disability and of Non-English Speaking Background: A model" (The Action on Disability within Ethnic Communities Inc., 1992), called for the design of programs and services with the capacity to be responsive to the cultures and languages of the users of the particular service provided.

In addition to the above, health care providers are becoming more aware of the need for client participation (Alexander, 1995), and clients are becoming more aware of their rights to be actively involved in aspects such as decision making with regard to service delivery (Weir, 1991).

2.4.4 Factors related to the Profession of Occupational Therapy

In line with and as a result of some of the international trends previously mentioned, occupational therapy service delivery in South Australia has undergone several developments,

e.g. the active involvement of the client in the application of the client-centred approach and the growing need for evidence-based practice. Changes have also occurred within the organisational structures in which occupational therapists in the field of early intervention are employed and should also be taken into account. Occupational therapists in these settings most often find themselves working in multi-disciplinary team structures, some of which do not report to a discipline-specific line manager.

Another point that is noteworthy is South Australia's statistics on occupational therapy staffing levels. Informal reports indicate that occupational therapy services in South Australia are in high demand, but that financial cutbacks in health care have resulted in less full-time employment being available, causing heavy workloads for therapists already employed. Statistical information on occupational therapists in Australia is very limited. The President of the National Association for Occupational Therapists, OT Australia (South Australia), indicated that South Australia has significantly lower staffing numbers in early intervention than other states (Ramsay, 2001). The Occupational Therapy Registration Board of South Australia (2001) indicates that 586 occupational therapists are actively registered, of whom 491 (84%) are currently employed. This is the third lowest registered number when compared with other states (indicated in 1998): Victoria – 1 567; Queensland – 989; Western Australia – 952; Australian Capital Territory – 101 and Northern Territory – 79 (AIHW, 2001).

International literature provides some examples of strategies utilised by services to overcome staffing-related issues. Salvatori (1997) identifies a number of strategies for occupational therapists to consider in reaction to the changes in the health care system in Canada. Pong (in Salvatori, 1997) describes the options of collaborative practice, personnel substitution, and multi-skilling. The author emphasises collaborative practice in view of the need for coordinated, continuous service delivery. Personnel substitution refers to the use of other service providers to do the work usually done by providers with specific qualifications,

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credentials, or titles. Pong states that the use of substitutes such as nurse practitioners, physician assistants and midwives has been proven to be safe and cost effective.

Von Zweck and Gillespie (1998) discuss the use of support staff in occupational therapy, and Hagler (in Salvatori, 1997) suggests that certain tasks typically performed by occupational therapists may be effectively delegated to support personnel. Pong describes multi-skilling as the cross-training of a service provider to perform procedures and functions in two or more disciplines. Multi-skilling has been used successfully in America with technical personnel, and in Canada with nurses (Salvatori, 1997). This author, as well as Foto (1996), suggests that multi-skilling and personnel substitution are strategies that may be explored by occupational therapists in order to deal with staff shortages and deliver a cost-effective service. Harbin, McWilliam and Gallagher (2000) name the following strategies that resulted from staffing shortages in the USA: a trans-disciplinary approach, the use of therapists as consultants with individuals who work more regularly with the children, as well as the implementation of intervention in the natural environments of children.

Within this framework of current trends and changes in the context of early intervention service delivery in South Australia, it is evident that programs – in particular occupational therapy programs, for the purposes of this study – need to reflect regularly on the appropriateness of their services in order to ensure that such services keep up with society's changing demands. These changes provide challenges for service providers in this field.

2.5 CHALLENGES FOR EARLY INTERVENTION SERVICE DELIVERY IN SOUTH AUSTRALIA

Occupational therapy services seem to have been slow in taking on early intervention as a priority, even though health care and other government policies, as well as funding priorities, support this direction. Due to a number of difficulties, as mentioned previously in this chapter, services have been struggling to adhere to these policies. Some early intervention

services in South Australia are in the process of considering changes or are already undergoing changes to their service delivery models, with a greater focus on health promotion.

References to the difficulties encountered in changing traditional ways of service delivery are found in the international literature. Difficulties may be due to the fact that societal and policy changes require fundamental shifts in service delivery (Harbin, McWilliam & Gallagher, 2000). Further changes that personnel are required to make, are mentioned by Klein & Gilkerson (2000), and include: skills in developing respectful, collaborative relationships with families; becoming systems thinkers; developing capacity for reflection and self knowledge; and the use of interdisciplinary or collaborative teaching and learning. These authors mention the need for personnel to be able to work effectively with adult learners, and understanding the impact of changes in the larger social system.

Challenges for services are to consider changes in line with the factors impacting on service delivery. Figure 1 provides a consolidation of the factors that were discussed previously in this chapter, with the focus on the service system. It provides a framework that may be used when services are evaluating their current service delivery models and considering changes. An assessment of environmental influences impacting on service delivery needs to include factors such as those found within the sociological, demographical, political and economic arenas. In addition, the overriding principles of primary health care need to be considered. Items included in an internal assessment include client age and type; the intervention strategies used by the service versus current trends of practice (discussed under "International Trends" within this chapter); and organisational or service-related factors (refer to Table 2). These aspects, coupled with the identification and assessment of specific problematic areas within the service, such as long waiting lists and inadequate supplies of staff, should give rise to the question on whether change is required within current service

delivery models. Further referencing to Figure 1 are included in Chapter 4, Research Design and Methodology.

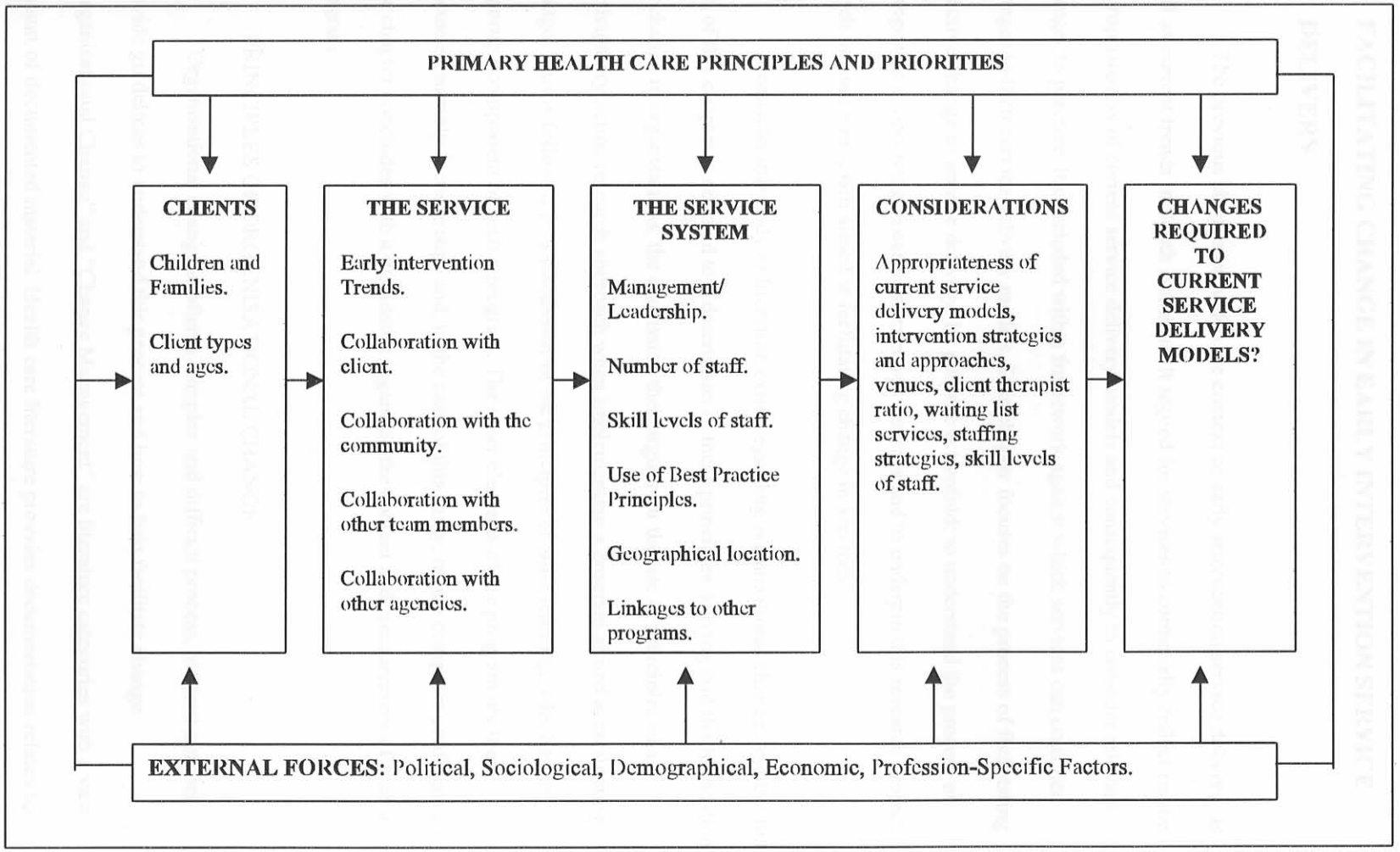
Various authors advocate that services consider the use of a combination of models that are suitable to both the core principles of occupational therapy (Boyt Schell & Slater, 1998) and the specific population characteristics (Dunn, 2000; Case-Smith, 1997; Cromwell, 1984). A survey by Case-Smith and Cable (1996) reveals that the use of multiple models in school-based services is effective. Letts, Fraser, Finlayson and Walls (1993) add to these contributions by stating that health care – in the form of clinical treatment services; disease prevention – in the form of lifestyle modification and health education; as well as health promotion – in the form of collaborative, intersectoral action in order to reduce inequities, enhance coping and create healthier environments, should all be considered as complementary approaches. In addition, Halpern (2000) and the National Research Council and Institute of Medicine (2000) advocate a mix of parent support and individualised intervention programs.

2.6 SUMMARY OF CHAPTER

Chapter 2 provides a framework of changes and trends in the early intervention field, the challenges in changing practice and the need for occupational therapists to reflect on their services and consider ways of meeting new demands. The discussion in Chapter 3 focuses on the process of change in organisations, since its relevance is significant in the current context of service delivery in South Australia.

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Figure 1 Factors influencing the Early Intervention Service Delivery Process



3 FACILITATING CHANGE IN EARLY INTERVENTION SERVICE DELIVERY

The previous chapter provided the context of early intervention service delivery, as well as current trends in South Australia. It argued for services to continually reflect on the appropriateness of current service delivery models and consequently to consider relevant changes to practice. It concluded with a framework against which services can consider changes to their service delivery models. This chapter focuses on the process of facilitating effective change in service delivery. Its purpose is twofold: to understand the process of change that is occurring in early intervention services and to underpin this research project, which utilised a program aimed at facilitating change in services.

A considerable body of literature exists regarding organisational change, and the first part of this chapter is devoted to a description of these principles. Having laid the foundation for change in organisations, the discussion then argues for the use of principles of a participatory action research approach when implementing a program aimed at facilitating change. This is followed by a discussion of the principles of adult learning, which is an important component of such a program. The other elements of the program are then discussed, namely focus groups and, in the case of this study, online computer conferencing. The chapter concludes with a discussion regarding the content and measurement of such a program.

3.1 PRINCIPLES OF ORGANISATIONAL CHANGE

Organisational change is often a complex and difficult process. Various authors provide guidelines to understand this process and how to best facilitate change. "Organisational Change" and "Change Management" are literature categories with a vast amount of documented material. Health care literature provides documentation related to Organisational Change, such as Marzaleck-Gaucher and Coffey (1991), Cook (1995), and

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Cope (1981). This part of the chapter explores the process of change and the elements of organisational change.

3.1.1 The Process of Change

According to Winton and McCollum (1997), the process of change is ongoing in today's organisations, due to the continual changes in organisations' environments. Lewin (1946) provides the first description of the process of change, which includes the phases of unfreezing (identifying the problem); moving (implementation of new strategies); and refreezing, which is the end result of the process of change, and results in stability. The unfreezing phase is often a difficult process, since it involves moving away from the old comfortable way of doing things to a new, unfamiliar way (Peters & Tseng, 1983; Cope, 1981).

The foundation for change is an internal personal process of change, according to Burkey (1993) and Schurink (1998). This personal development involves the acquisition and internalisation of knowledge and information. The process of change therefore needs to include as a foundation the process of personal change, which is achieved by means of educational opportunities for individuals in order to acquire and internalise information. Wright (1989) supports this view by stating that the process of change starts with the gathering of information.

Change is a problem-solving process, according to Bair and Gray (1992), and the following steps can be identified in the problem-solving process: firstly, the identification of the problem (Marzalek-Gaucher & Coffey, 1991; Wright, 1989; Berger, Elhart, Firshich, Jordan and Stone, 1980; Vestal, 1995); a clear investigation of the problem; the generation of possible strategies to solve the problem; the selection of a particular strategy; the implementation of the strategy; the evaluation of the effectiveness of the adopted strategy; and corrective action, if required. The recognition of the need for change may be added to the

initial steps in this process (Marzalek-Gaucher & Coffey, 1991). A vast number of examples of projects that support these processes of change are available in the literature. Examples include Cook (1995), The Australian Early Intervention Network for Mental Health in Young People (2000), and Peters and Tseng (1983).

3.1.2 Elements of Change

Various authors provide information on the critical elements that need to be considered when facilitating change within an organisation. These elements may be consolidated into categories related to the organisation, its management and its personnel.

Marzalek-Gaucher and Coffey (1991) describe the organisational factors that impact on change as the role of management; an external focus that includes the evaluation and scanning of the environment; a well-understood mission and goals; strategic planning and responsiveness to customers' requirements, and the fostering of relationships with suppliers. Vestal's (1995) organisational forces that impact on the choice of service delivery, provide more organisational elements for consideration, namely the mission and goal of the organisation, the desired level of service quality, and the resources available.

Several authors have focused on the critical role that management and leaders play in facilitating organisational change (Peters & Tseng, 1983; Bailey, Schermerhorn, Hunt & Osborn, 1991; Bair & Gray, 1991; Marzalek-Gaucher & Coffey, 1991). Bair and Gray (1991) state that part of a manager's job is to act as a problem solver and change agent. A change agent may be defined as a person or group that takes responsibility for changing an existing pattern of behaviour. This author emphasises the need for managers to be open to new ideas, to be able to identify situations that require change, and to support the implementation of new ideas. Marzalek-Gaucher and Coffey (1991) name the following characteristics of successful managers acting as change agents: the identification of the need for change; a pro-active approach; planning; clear vision and goals; innovation; creativity; the ability to involve and

empower employees; and adaptability. They add the following to this list: being a visionary; being socially responsible; being flexible; having self-knowledge; and being commitment to continual professional training. Jacobs (1999) emphasises the importance of managers considering different points of view and continually analysing situations critically.

The literature provides evidence of the essential component of active involvement of all members (that is, all personnel) involved in the process of change, in order for change to be successful and lasting (Cope, 1981). This author, amongst various others, emphasises the importance of facilitation of ownership of change by means of the involvement of participants. French and Bell (in Cope, 1981) agree by stating that people tend to support what they have helped to create. Having explored the process of change and its elements, these principles are now applied to a program aimed at facilitating change in organisations.

3.2 FACILITATING CHANGE IN ORGANISATIONS

3.2.1 Participatory Action Research Approach

It is against this background that it becomes logical to use elements of the participatory action research approach when facilitating change in service delivery. Participatory action research refers to a design in which participation forms the core of the research process and in which the project leads to action (Rahman in Schurink, 1998). This design is particularly appropriate in cases where problem solving and improvement are on the agenda (Hart & Bond, 1995). This design may result in the initiation of change at the levels of both individual professional practice and organisational structures and processes.

Its core principle is that those who experience a phenomenon are best qualified to investigate it (DePoy & Gitlin, 1998). Kurt Lewin (1946) first introduced the concept of action research. Its main focus was for use in community work and to improve social conditions. Two important principles, namely group decision making and commitment to improvement, emerged from Lewin's work and still form the core of action research today.

Kemmis and McTaggart (1988) further developed on the ideas of Lewin. These authors emphasised the nature of action research as a collective enquiry tool to improve on social and educational practices. They emphasised the value of action research in understanding one's own practices and the situations in which they are carried out.

Bowling (1997) adds to the rationale for the use of the participatory action research design: it is undertaken to improve practices and the understanding of them and it was designed to study social systems with the aim of changing them. This method has been used in local working environments in order to define needs and problems and to devise methods of dealing with the problems and improve services. By using this method, a researcher empowers participants to act on their own behalf as active participants in making changes (Hart & Bond, 1995).

This design proves to be appropriate especially when considering the nature of the process of change, which requires a process of problem identification; critical reflection; exploration of different options; a period for implementation of change, and eventually an assessment of such change. The participatory action research design matches this cyclic pattern well, since it involves a similar cyclic process in which research, action and evaluation are interlinked. Furthermore, the participatory action research design facilitates the active involvement of participants, which is essential for the process of change.

Various authors support this design when organisational change is on the agenda, and examples exist of successful participatory action research projects aimed at facilitating change in organisations, including those of Hart and Bond (1995), Barton Cunningham (1993), East and Robinson (1994), Cope (1981), and Bair and Gray (1991). The participatory action research design is therefore a suitable approach to facilitate change in service delivery, since it matches the criteria of participation, collaboration and empowerment.

Within the participatory action research design, one needs to consider how best to facilitate change. In the application of the principles of change, the following essential components can be identified, namely: the involvement of managers of services as participants due to their central role in facilitating change; the utilisation of a training program in order to acquire and internalise information; the facilitation of opportunities for the recognition of the need for change; the identification of the problem; a clear investigation of the problem; the generation of possible strategies to solve the problem; the selection of a particular strategy; the implementation of the strategy; and the evaluation of the effectiveness of the adopted strategy and corrective action, if necessary.

This program needs to be implemented within the context of each organisation's management, organisational and personnel elements that impact on the process of change. Furthermore, the program needs to centre on sound adult learning principles, and the active participation and involvement of participants in order to facilitate effective change. In addition to the principles of organisational change, the principles of adult learning must also be considered, since they form an essential part of the basis for change.

3.2.2 Principles of Adult Learning (Androgogy)

Androgogy attempts to explain the phenomenon of adult learning while acknowledging its richness and complexity (Merriam in Knowles, 1998). Knowles mentions the direction of "perspective transformation", which has been documented by Mezirow (1981). This field of adult learning focuses on critical reflectivity, which forms the basis for change. Mezirow defines transformative learning as a critical reflection of current beliefs, norms and views that lead to reinterpretations of current and past behaviour into a new perspective. Gravett and Peterson (2000) also describe transformative learning as a process that occurs when a person is faced with a dilemma and that leads to the modification of old views and the development of new ones. According to these authors, critical reflection includes a deeper awareness of current views and an assessment of alternative views. It

includes a decision to negate old views or to make a synthesis between old and new views. Mezirow (1981) states that this synthesis needs to be followed by action based on the newly developed view.

In additional to this, Gravett and Peterson (2000) emphasise the significance of opportunities to articulate and engage in dialogue regarding current practices. Barnes and Todd (in McConnell, 1994) also advocate the use of communication and cooperation in education. These authors state that social interaction in cooperative groups produces superior problem-solving skills. Talking about a topic increases one's understanding and learners are more actively involved in the topic. This latter view is also supported by Walkin (1990), who contributes by stating that adults respond better to methods that encourage active involvement in their learning. When considering the participative nature of such a learning context, it seems logical to consider the use of focus groups in a research project of this nature.

3.2.3 Focus Groups

Focus group discussions seem appropriate for a number of reasons. Group discussions allow for collaborative learning opportunities as well as active involvement in the process of change. Morgan (1998) states that focus group discussions create sharing and comparisons amongst participants. By means of focus groups, participants are exposed to a range of experiences and opinions. Krueger (1994) states that attitudes and perceptions regarding different aspects, including services, are developed in part by means of interaction amongst other people.

In addition to the use of focus groups in a program aimed at facilitating change, the South Australian context also needs to be considered. With vast distances between towns in which early intervention services are situated, attendances at regular face-to-face focus group discussions become a challenge for many prospective participants. A further complication is the time commitments of managers to attend face-to-face focus group discussions. Within

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this context, online computer conferencing may be a consideration for overcoming such practical difficulties.

3.2.4 Online Computer Conferencing

Online computer conferencing is an option for focus group discussions. The advantage of using online discussions is that participants can participate in their own time and in a place that is convenient to them (McConnel, 1994; Lewis & Kaas, 1998; Ryan, Carlton & Ali, 1999). In addition to this rationale, the researcher and her supervisors have experience in the use of online discussion groups.

Online discussion forums provide a common meeting place on the Internet for participants to contribute information. Communication occurs by means of posted messages that appear in the form of a threaded discussion. Messages are grouped under the same topic heading to makes it possible for focus group members to follow different topics within a discussion. Asynchronous discussion is one type of online discussion. This means that discussion does not occur simultaneously with other participants and that participants are not present online at the same time. The advantage here is that participants can participate at a time that is suitable to them. The conversation differs from a synchronous online chat, where the software allows for the rapid, simultaneous exchanging of messages amongst participants. Online computer conferencing again refers to the occurrence of the discussion within a set time frame to facilitate intensive discussion within a specified period.

McConnel (1994) supports the use of this medium for collaborative learning, critical analysis, and active involvement. In addition, it also has the advantage of the acquisition of multiple perspectives (Cartwright, 2000). Several studies have found that online discussion facilitates critical reflection, analysis, and in-depth exploration of a topic due to the time available between reading a message and composing one's own (McConnel, 1994; Cravener, 1999). Ryan, et al. (1999) comment on the increase in networking possibilities with

colleagues that online discussions provide. These authors, amongst others, also note the clear, organised and focused way in which online discussions can occur.

Being a relatively new field in both education and research, very limited research information is available regarding the practicalities of the use of online computer conferencing for research purposes. The literature centres on mainly two categories: the use of online discussion forums in education; and their use in support groups in health care. Information obtained from literature regarding education serves as a guide in the planning and development of an appropriate discussion forum. Several studies make recommendations for well-structured and user-friendly designs (Halstead, Reising and Billings, 1995; O'Brien and Renner, 1999; Scordo, 1997).

Research studies that have used online discussion as a medium have focused mainly on its use in support groups. The studies conducted by Dickerson, Flaig and Kennedy (2000), Klemm, Reppert and Vision (1998), Weinberg, Schmale, Uken and Wessel (1995), and Brennan, Moore and Smythe (1995) focused on the use of online discussions as a support structure for various terminally ill patients and their caregivers. It proved to be a valuable communication medium via which patients and caregivers could share information, concerns and ideas. Limited details were provided on the structure of these discussion forums or suggestions for their future use. Most reports analysed their effectiveness by analysing the online discussion themes and the number of messages posted.

Against this background, it seems appropriate to conduct focus group discussions by means of online computer conferencing, which would provide qualitative data and would be one of the first research studies to utilise this medium. Having established the approach and medium of delivering a program aimed at facilitating change, this chapter will now focus on the content and measurement of such a program.

3.2.5 Content of a Program aimed at facilitating Change

In order to provide the opportunities for the steps in the problem-solving process to occur, the content of a program aimed at facilitating change should be selected to make provisions for these steps. The content of the program should focus on identifying problems in current service delivery models and the need for change, and on investigating the nature of the problem and possible strategies to solve the problem. It should allow time for the implementation of strategies and the evaluation of such strategies. The content should be appropriate and participants should therefore be actively involved in selecting and assessing the content of such a program. A diagrammatic layout is provided in Figure 2. The proposed phases will be discussed in more detail in Chapter 4.

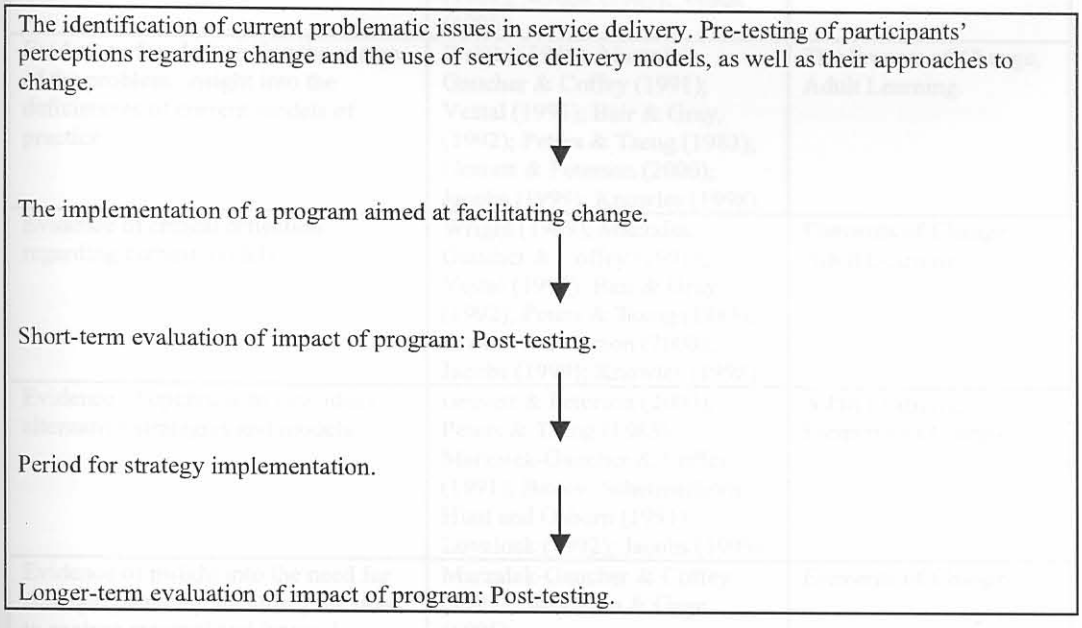
3.2.6 Measurement of a Program aimed at facilitating Change

Evaluation of the process of change is crucial to its success (The Australian Early Intervention Network for Mental Health in Young People, 2000). It is necessary to measure the impact of the program by means of both a pre-test and a subsequent post-test after the implementation of the program. In addition, change can be measured throughout the implementation of the program, and after a certain amount of time, once the program has been implemented.

Pre-set indicators for change in the perceptions of managers, as well as changes in practice, need to be developed from the start, as recommended by the Australian Early Intervention Network for Mental Health in Young People (2000). Table 4 provides a layout of the indicators for a program aimed at facilitating change. These indicators are underpinned by guidelines provided by authors of Change Management and Adult Education literature as discussed previously in this chapter. Perusal of literature occurred until a point of saturation in the literature was reached, where no new indicators were indicated. These indicators relate to the early stages of acquiring information, to problem solving, and to critically reflecting on

current practice and the newly acquired information. Indicators also relate to the identification of approaches to change, for example "openness to new ideas". In addition, indicators refer to aspects of learning, such as interest and motivation, that may occur in the focus group discussions

Figure 2 Graphical Representation of a Program aimed at facilitating Change



In addition to these indicators, longer-term indicators for change in practice have been adopted from the New South Wales Department of Health (1998), which developed a strategic framework for capacity building in organisations. The study, executed by the Australian Early Intervention Network for Mental Health in Young People (2000), utilised this framework, which consists of three areas as indicators for the evaluation of changes in early intervention services. These include workforce development towards implementing change, organisational development towards implementing change, and allocation of resources to implement change. The Australian Early Intervention Network added a fourth indicator: the development of partnerships and networks in order to implement change. Together, these indicators provide a longer-term indication of change and seem to comprehensively cover the most significant factors in implementing change.

Table 4 Indicators of Change for a Program aimed at facilitating Change

Indicator	Literature Reference	Previous Reference in Chapter
Evidence of identification of problems related to current service delivery models.	Bair & Gray (1992); Marzalek-Gaucher & Coffey (1991); Wright (1989); Berger, Elhart, Firshich, Jordan & Stone (1980); Vestal (1995).	The Process of Change.
Evidence of identification of the need for change in current service delivery models.	Cook (1991); Marzalek-Gaucher & Coffey (1991); Berger et al. (1980); Wright (1989); Vestal (1995).	The Process of Change.
Evidence of understanding the nature of the problem: insight into the deficiencies of current models of practice.	Wright (1989); Marzalek-Gaucher & Coffey (1991); Vestal (1995); Bair & Gray, (1992); Peters & Tseng (1983); Gravett & Peterson (2000); Jacobs (1999); Knowles (1998).	The Process of Change, Adult Learning.
Evidence of critical reflection regarding current models.	Wright (1989); Marzalek-Gaucher & Coffey (1991); Vestal (1995); Bair & Gray (1992); Peters & Tseng (1983); Gravett & Peterson (2000); Jacobs (1999); Knowles (1998).	Elements of Change, Adult Learning.
Evidence of openness to new ideas / alternative strategies and models.	Gravett & Peterson (2000); Peters & Tseng (1983); Marzalek-Gaucher & Coffey (1991); Bailey, Schermerhorn, Hunt and Osborn (1991); Lovelock (1992); Jacobs (1999).	Adult Learning, Elements of Change.
Evidence of insight into the need for strategic planning, including the need to analyse external and internal environments of services.	Marzalek-Gaucher & Coffey (1991); Shakleton & Gage (1995).	Elements of Change.
Evidence of internalisation of information: indication of preferences (positive or negative) in terms of information presented.	Walkin (1990); Burkey (1993); Schurink (1998).	Principles of Organisational Change, Adult Learning.
Evidence of internalisation of information: indication of the application of information.	Walkin (1990); Burkey (1993); Schurink (1998).	Principles of Organisational Change, Adult Learning.
Evidence of internalisation of information: indication of the assessment of different views.	Gravett & Peterson (2000); Burkey (1993); Schurink (1998).	Principles of Organisational Change, Adult Learning.
Evidence of internalisation of information: identification of positive and / or negative aspects of the model.	Mezirow (1981); Burkey (1993); Schurink (1998).	Principles of Organisational Change, Adult Learning.
Evidence of a decision made to negate current views regarding service delivery models.	Gravett & Peterson (2000).	Adult Learning.
Evidence of a synthesis of old and new views.	Gravett & Peterson (2000).	Adult Learning.

Table 4 Continued

Indicator	Literature Reference	Previous Reference in Chapter
Motivation to learn, interest in information, and attention given.	Walkin (1990).	Adult Learning.
Active participation in discussion.	Walkin (1990).	Adult Learning.

When evaluating the changes occurring in practice, it is essential to ensure that the program is implemented with the necessary measures in place to ensure the appropriateness of the program itself, as well as the validity and reliability of the information obtained from the program for research purposes. It is against this background that the following measures prove to be essential for consideration: the implementation of sound evaluation procedures at the beginning, during, and at the end of the program; consideration of the context of each organisation when interpreting findings; the implementation of strategies to reduce researcher bias; the use of scientifically sound measurement instruments; the use of scientifically sound data analysis procedures; the use of a combination of research methods, instruments and analysis techniques to acknowledge the complexity of the phenomenon. These measures are discussed in more detail in Chapter 4, since it relates to each phase of the study.

3.3 SUMMARY OF CHAPTER

Chapter 3 provides background information for understanding the processes that take place when facilitating change in organisations. It is within this framework that this research project focuses on the processes of change that occur in early intervention service delivery in South Australia, by implementing a program for this purpose. The discussion in Chapter 4 focuses on a detailed layout of the research design and methodology utilised in this research project and builds on the processes discussed within this chapter.

4 RESEARCH DESIGN AND METHODOLOGY

This chapter presents the research design and methodologies used in the research project on which this thesis is based. The research aims are provided first, followed by the research approach and design. This section supports the argument for a naturalistic design with features of the participatory action research approach, introduced in the previous chapter, which comprises a combination of data collection methods. The researcher's role during the execution of the project is subsequently discussed. This is followed by discussions of the sampling method, recruitment, and ethical considerations, and a description of the participants. The discussion is concluded with a description of the evaluation tools, the program aimed at facilitating change, and the processes and strategies utilised during this project.

4.1 RESEARCH AIMS

This study was conducted in order to document the perceptions of occupational therapy managers regarding changes that are occurring in occupational therapy services within the field of early intervention in South Australia.

4.2 RESEARCH APPROACH, DESIGN AND QUESTIONS

Elements of the participatory action research design – a particular naturalistic design – were utilised due to the design's unique principles of participation in the study and its focus on facilitating action as a result of the study. The naturalistic approach ensured that the phenomenon could be studied holistically within specific contexts, and that the life experiences from the perspective of those in the field could be captured. (DePoy & Gitlin, 1998). In addition, the structure of a pre-post test design was utilised to measure the impact of the program on the perceptions of participants.

The study was conducted by means of Phases 1–3 over a six-month period in order to answer the following main research question:

What are the primary changes observed in managers' perceptions regarding early intervention service delivery after exposure to a program orientated towards facilitating change?

In order to address this question, sub-questions were considered during each phase of the project. Phases 1 to 3, and their corresponding sub-questions and research instruments, are illustrated in Table 5. Phase 1 focused on the current status of service delivery by means of the pre-intervention questionnaire and the first online focus group. Four online focus groups were utilised during Phase 2 in order to introduce a program aimed at facilitating change. Data collected during this phase aimed at determining managers' approaches to change during the implementation of the program. Short questionnaires were administered after each focus group discussion. The cycle ended with an evaluation phase, during which the post-intervention questionnaire was administered, and follow-up interviews were conducted. This occurred at eight and 16 weeks after the completion of the program respectively. This phase aimed at answering the main question about the study and obtaining an understanding of what managers perceived to be the principles of best practice in the field of early intervention.

4.3 THE ROLE OF THE RESEARCHER

The role of the researcher played a significant part in the project, and required specific consideration during the execution of the project. As prescribed by the participatory action research design, the researcher forms an integral part of the research. She facilitated and resourced the online discussions and was a co-participant in the discussions, while maintaining objectivity in order to study the phenomenon without bias.

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Table 5 The Phases of the Project with corresponding Research Sub-questions and the Research Instruments

Phases of the Project	Research Sub-questions	Research Instruments of each Phase
Phase 1: Pre-intervention Phase	What are the current service delivery models employed by early intervention services?	Pre-intervention Questionnaire
	What is the context of current service delivery?	Focus Group 1
	What are the perceptions of managers regarding their current service delivery models?	Short Questionnaire
	What are the managers' approaches to change?	
Phase 2: Intervention Phase	What are managers' approaches to change during a program orientated towards facilitating change?	Focus groups 2–5
		Short Questionnaires
Phase 3: Evaluation Phase	What are the primary changes observed in managers' perceptions regarding early intervention service delivery after exposure to a program orientated towards facilitating change?	Post-intervention Questionnaire
	What are managers' perceptions of the principles for best practice in early intervention?	Interviews

In order to undertake this role effectively, the researcher had to establish her credibility amongst colleagues to study the phenomenon. Being new to Australia and not working in a paid capacity in the field of early intervention required some strategic networking beforehand not only with the Occupational Therapy Association and the University of South Australia, but particularly with the participants, in order to gain their trust and acceptance as a colleague. An initial meeting between the researcher and each participant occurred in order to ensure an understanding of what the project entailed; to facilitate acceptance and participation in its goals and methods, as well as a cooperative attitude (Barton-Cunningham, 1993). It was very important to establish a participatory and positive attitude towards the study from the outset. This ensured maximum response rates, and a commitment to participate in all the phases of the project, and contributed to the participants taking ownership of the project. All these aspects were essential given the heavy time commitments of participants and the lengthy timeframe of the project. The cooperation, active

participation and involvement of the participants formed the core of the process of facilitating change.

4.4 SAMPLING METHOD

A purposive sampling method was used according to which participants were purposively selected for the appropriate knowledge and experience regarding the early intervention service delivery that they possessed. Seventeen occupational therapy managers of early intervention services were invited to participate in the study. These included all the known services in South Australia – covering both metropolitan and country areas. The services were selected from various service directories. Fourteen organisations provided their consent and participated in the study.

For the purposes of this study, occupational therapy managers were seen as occupational therapists in senior roles with service coordination responsibilities. These managers' responsibilities might include areas such as personnel management (including the management of schedules and caseloads), resource and financial management, and the management and administration of record keeping – regarding both intervention details and statistical information (World Federation of Occupational Therapists, 1998). These functions of occupational therapy managers made them eligible to be selected to provide information regarding these areas. Equally important was the emphasis that the literature placed on the manager's essential role in the facilitation of change, and this added to the rationale for the selection of managers as participants.

The organisational structures of the participating services and early intervention teams varied significantly, with some having complex and non-traditional management structures within overlapping disciplines. In some instances, the participating therapist was serving as both manager and clinical therapist and in another, the management function was temporarily being attended to by the clinical therapist. To accommodate certain structures in some of the services, the manager and clinical occupational therapist participated in the study

together. Where a sole therapist served as clinician and also managed the paediatric services provided, this therapist was included. It was reasoned that this therapist has some management duties relating to the organisation of services, would be able to provide information on the services provided, and could play a role in facilitating change in the services provided.

4.5 RECRUITMENT OF PARTICIPANTS

A letter of invitation to participate in the study, stating the aim and use of the study and providing information about the study, was sent to the occupational therapy managers. A consent form was completed and returned to the researcher (see Appendix A). By completing the consent form, participants indicated their willingness to participate in all the phases of the project. The information sheet clearly indicated the different phases involved and the importance for participants to be involved in all the phases (see Appendix B). Prospective participants were made aware of their voluntary participation and they were in no way coerced into participation. Furthermore, they were made aware that they were free to withdraw from the study at any stage.

4.6 ETHICAL CONSIDERATIONS

Ethical approval and permission to conduct the study was obtained from the University of South Australia. All possible steps were taken to ensure an ethically sound study.

Participants were provided with the choice of either maintaining confidentiality or providing permission to use the names of their employers on the website and in the publication of results. One manager indicated the preference to maintain confidentiality. Consequently, measures were put into place to ensure the participants' anonymity. The identifying information on the completed questionnaires was removed once received; only first names were used during the focus group discussions (due to the context-specific nature of the topics under discussion, it was essential that participants knew who the other

participants were) and all identifying information was removed when the results were discussed and reported.

4.7 DESCRIPTIONS OF PARTICIPANTS AND AREAS COVERED

Fourteen participants participated in the study. The characteristics of the participating services and the participants are provided in Table 6 (in no specific order). The majority of the participating services (13) were government organisations, with one being a non-government organisation. Organisations included services from the Adelaide metropolitan area, as well as rural and remote areas (that is, non-metropolitan areas) in South Australia. The majority of services cover both urban and rural areas (64%), which include services to towns in regional areas. Metropolitan areas were covered by the second largest proportion (50%) of the participants and include city areas. Remote areas were covered by the third largest number of participants (36%) and include areas of low density, which are geographically isolated.

The four most prevalent client groups of the services were, in order of prevalence: development delays and scholastic difficulties (all services); cognitive / intellectual impairment (8 of the 14 services); neurological impairment (7 of the 14 services); and physical impairment (7 of the 14 services). Participants had more than one choice when answering this question.

Table 6 Characteristics of Participating Services and Participant

Participant Number	Type of Service	Client Ages	Geographical Area covered by Service	Management Role of Participant
1	Health Care	From birth, including school-aged children	Non-metropolitan areas	Sole clinical occupational therapist in paediatrics, manages aspects of service delivery
2	Disability Service	0–18 years	Metropolitan and non-metropolitan areas	Manager of occupational therapy services
3	Health Care	From birth, including school-aged children	Metropolitan and non-metropolitan areas	Manager of occupational therapy services and paediatric occupational therapist both participating
4	Health Care	From birth, including school-aged children	Metropolitan and non-metropolitan areas	Senior occupational therapist with coordinating responsibilities
5	Health Care	From birth, including school-aged children	Metropolitan areas	Manager of occupational therapy services
6	Health Care	0–6 years	Metropolitan areas	Manager of occupational therapy services and paediatric occupational therapist both participating
7	Health Care	From birth, including school-aged children	Metropolitan and non-metropolitan areas	Sole clinical occupational therapist in paediatrics, manages aspects of service delivery
8	Disability Service	6 years onwards, may include adolescents and adults at risk	Metropolitan areas	Sole clinical occupational therapist in paediatrics, manages aspects of service delivery
9	Health Care	From birth, including school-aged children	Non-metropolitan areas	Manager of occupational therapy services and paediatric occupational therapist both participating
10	Health Care	From birth, including school-aged children	Non-metropolitan areas	Sole clinical occupational therapist in paediatrics, manages aspects of service delivery
11	Health Care	From birth, including school-aged children	Non-metropolitan areas	Manager of occupational therapy services and paediatric occupational therapist both participating
12	Disability Service	0–6 years	Metropolitan areas	Senior occupational therapist with coordinating responsibilities
13	Health Care	0–3 years	Non-metropolitan areas	Acting manager for Allied Health Staff and clinical occupational therapist
14	Health Care	0–6 years	Non-metropolitan areas	Sole clinical occupational therapist in paediatrics, manages aspects of service delivery

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4.8 DESCRIPTIONS OF EVALUATION TOOLS AND THE PROGRAM AIMED AT FACILITATING CHANGE

4.8.1 Pre- and Post Program Evaluation Tools

Walkin (1990) recommended the evaluation of a training program in order to assess the effect of a course of study, or a training program. This author suggests the use of a criterion test both before and after training. This test, according to the author, should be based on the desired outcomes of the training program. This view is also supported by The Australian Early Intervention Network for Mental Health in Young People (2000) which conducted a study on the early intervention services in mental health.

4.8.1.1 The Questionnaire: Primary Considerations in the Development of the Questionnaire

A questionnaire was chosen as preferred research tool for the evaluation of the perceptions of managers both before and after participating in the program aimed at facilitating change. The pre-intervention questionnaire involved the collection of clear, unbiased factual data regarding the problem, which is essential as a basis for the process of change (Cope, 1981). It served as the baseline for understanding the current situation (Cope, 1981) and the need for change (Barton-Cunningham, 1993). In addition, practical considerations included that the participants were spread over a large geographical area, making the use of this tool appropriate.

The same questionnaire was administered both before and after the program, except for part A of the questionnaire, consisting mostly of organisation-specific questions, which was omitted in the post-intervention questionnaire.

During the development of the questions, attention was given to literature guidelines for questionnaire development (Fink, 1995a; Fink, 1995b; Borgue & Fielder, 1995; Abramson, 1990; Neutens & Rubinson, 1997) and examples of other similar questionnaires.

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Careful consideration was given to the development of the questionnaire, which included: the layout of questions; clearly defining operational definitions; ensuring that questions were clear and unambiguous; and the use of cross referencing for some questions. These measures ensured minimal variations in the data obtained. Consideration was given to the questionnaire design to ensure that all aspects were sufficiently covered. As many questions as possible were included in the questionnaire to cover the topic adequately and an exhaustive range of response categories was provided. These measures ensured that the questionnaire had a high content validity. By ensuring that all the questions were relevant and by using appropriate language and terminology, the face validity of the questionnaire was ensured. Definitions of terminology were included to avoid misunderstandings.

Table 7 provides a detailed layout of the motivation for the inclusion of each question and Appendix C provides the final pre-intervention questionnaire.

The draft questionnaire was reviewed by a statistician and paediatric occupational therapist. A pilot test, which involved one paediatric occupational therapist and one occupational therapist in a managerial position, was executed. The pilot test and peer review of the questionnaire ensured that the research instruments were appropriate and maximised the consensual validity of the questionnaire. Appendix D provides a detailed layout of the changes made to the questionnaire as a result of the pilot test. The pilot test included a trial for the use of the planned procedures when completing the questionnaire as well as the use of the data analysis methods. Changes were made, where required, and the final questionnaire was developed.

4.8.1.2 Development of the Follow-up Interviews

The aims of the follow-up interviews were to provide further qualitative information on the longer-term changes in the perceptions of managers. In addition, it served to strengthen the data gathered during the administration of the pre-intervention questionnaire and the focus

group discussions by repeating certain critical questions in the questionnaire and providing the opportunity for qualitative data collection and in-depth discussion during the interviews.

The interviews were semi-structured since questions were developed using a standard format, which was adapted to each organisation according to the information that had been provided on the questionnaires and during the focus group discussions. Questions were developed to further discuss each organisation's context and processes of change. In addition, questions were developed to facilitate discussion that would elicit the pre-set indicators (refer this chapter, Table 12 and Table 13).

The first interview served as a pilot test, with no changes made to the wording of questions or the procedures. Table 8 illustrates the basic format of the interviews, the reasons for the inclusion of each question, and examples of how the questions were applied to participants' contexts.

4.8.2 Development of a Program aimed at facilitating Change

Phase 2 included online focus group discussions. Focus group discussions employ guided discussion to generate a rich understanding of participants' experiences and beliefs (Morgan, 1998), and of perceptions related to a defined area of interest (Krueger, 1994). The rationale for utilising this medium was provided in Chapter 3, Focus Groups.

4.8.2.1 Online Focus Groups

The focus group discussions were conducted by means of five online discussions. Online focus groups were utilised for their qualities of making discussion convenient at a time and place suitable for participants from across South Australia. The online focus group discussions occurred in the form of computer conference sessions. The duration of each of these conferences was one week. This meant that participants could enter the discussion rooms anytime during the week to participate in the discussion.

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Table 7 Considerations regarding the Development of Questions included in the Questionnaire

Questionnaire Category	Reason for Inclusion	Examples of Questions
Description of the participating organisations.	To provide descriptive and contextual information regarding the participating organisations, as discussed in Chapter 2 (refer Figure 1).	Please indicate the approximate range in kilometres covered by your department's service: Between 5 and 15 kilometres; Between 15 and30 kilometres; Between 30 and 50 kilometres; Between 50 and 100 kilometres; More than 100 kilometres.
Description of the services delivered.	To provide descriptive and contextual information regarding the services delivered, as discussed in Chapter 2 (refer Figure 1).	Please indicate your department's main area of practice: Physical impairment; Cognitive / intellectual impairment; Psychiatric impairment; Development delays and scholastic difficulties; Neurological impairment; Medical / surgical; Medico-Legal; Other, please specify.
Description of management and the management practices utilised by the participating organisations.	To provide descriptive information related to management, management training, styles of management and management practices utilised, as discussed in Chapter 2 (refer Figure 1) and Chapter 3, The Process of Change.	Does your department function according to a strategic and / or business plan? Yes; No; Unsure.
Description of the type of service delivery models currently employed.	To provide information regarding current service delivery models in practice, as discussed in Chapter 2 (refer Figure 1) and Table 2.	Please indicate which of the following service delivery models your department employs: (Please see definitions provided). Consultation; monitoring; direct, one-to-one; direct, group; multi-disciplinary; interdisciplinary; trans-disciplinary; Case management; Other, please specify.
Description of service delivery issues.	To provide information on perceptions related to service delivery issues.	Do you feel that the current venue/s used by your organisation are effective and adequate for occupational therapy service delivery? Yes; No; Unsure.
Consideration to the use of strategies.	To provide information on perceptions related to consideration of the use of strategies to address issues, as discussed in Chapter 2, Factors Related to the Profession of Occupational Therapy.	Please indicate whether you would consider the use of any of the following strategies in the future: (Please see definitions provided) personnel substitution; therapy assistants; multi-skilling of support staff; multi-skilling of therapists. Yes; No; Unsure.
Perceptions regarding changes in service delivery models.	To determine perceptions regarding the need for change and foreseen difficulties in facilitating change.	Do you perceive a need for change in the service delivery models of your department? Yes; No; Unsure.

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Table 8 Interview Questions and Reasons for the Inclusion of Questions

Topic Covered	Reason for Inclusion	Questions asked
Usefulness of discussion groups.	To determine usefulness and relevance of discussion groups for each participant. To identify context-specific issues for each participant. To elicit pre-set indicators.	It has been two months since our discussion groups, can you tell me a bit about your feelings regarding how useful the discussion groups were for you?
Perception regarding the need for change a) If no: Perception regarding what is working well.	To elicit pre-set indicators.	You have indicated in the questionnaire that you do not perceive a need for change in the way you deliver services – Could you explain what is working well and why you want it to continue?
Perception regarding the need for change b) If yes: Plans for change or changes implemented.	To elicit pre-set indicators.	You have indicated in the questionnaire that you perceive a need for change in the way you deliver services: Could you tell me about the plans you have for change or the changes you may already have implemented? You have indicated that you are considering a multi-discipline Maroondah approach, could you tell me about your plans?
c) Factors that have brought on changes.	To identify the context-specific issues for each participant. To determine whether the discussion groups played a role in facilitating change.	Could you tell me about the events / factors which have brought on these changes? You have mentioned that you have moved from being a sole practitioner working with schools to a trans-disciplinary approach – can you tell me about the events / factors which have brought on these changes?
d) The effects of the changes.	To describe the context in which changes are occurring as well as the positive effects and the barriers to change.	What have the effects been of these changes? Have you experienced positive effects of the changes? You have indicated during the focus groups that your organisation supports innovation and improvement… Have you experienced barriers to these changes? You have indicated the varied nature of your caseload…

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Table 8 Continued

Topic Covered	Reason for Inclusion	Questions asked
Broader plans and changes ahead for services.	To describe broader context of services. To elicit pre-set indicators.	Are there any broader future plans ahead for your service? This might include external and internal changes that you may be aware of. What is the vision for your service for the next three years? Are you in favour of this vision? How do you see your service fitting in with this vision?
Other significant issues related to project or service delivery.	To provide the opportunity to raise any issues which have not been captured in the previous phases of the project. To provide the opportunity for more in-depth discussion of an issue which may not have been possible in the online discussion groups.	Are there any significant issues or strategies regarding service delivery which have not been covered by this project and which you would like to talk about / emphasise? You mentioned a unified approach and some sort of communication network – can you elaborate more?
Perception regarding best practice.	To compare perception with current service delivery models used. To elicit pre-set indicators. To provide a descriptive framework of best practice principles across all organisations.	Could you tell me what are your perceptions regarding best practice in the delivery of paediatric services?

4.8.2.2 Preparations for a Program aimed at facilitating Change

The literature suggests that sufficient time should be spent on the planning of focus groups (Morgan, 1998) and the preparation and orientation of participants (Milstead, 1998; Halstead, Hayes, Reising & Billings, 1995; Lewis & Kaas, 1998) in order to maximise the success of online group discussions. Participants were prepared by meeting with them beforehand; providing adequate information; ensuring that participants knew what was expected of them, and reminding them of their participation. Adequate written information regarding the use of an online discussion forum and the different phases involved in the project were provided (refer Appendices E and F). Specific measures included asking participants to log in at least a week before the discussion was to commence to post a greeting in order to sort out problems before the discussion commenced.

Further preparations included attending to the design and layout of the discussion. A simple book design was utilised, as described by McConnel (1994), where messages are posted one below the other, according to topics. This ensures that participants can find their way in the discussion and it minimises information overload. Steps were taken to ensure the availability of technical support as suggested by various authors (Akers, date unknown; Lewis & Kaas, 1998; Ryan, Carlton & Ali, 1999; Milstead, 1998).

Care was also taken to ensure that participants knew how to select topic headings carefully and how to respond to a new message. In addition, measures were included to remind participants to enter the discussion room and participate in the discussion. The researcher undertook this role, and reminded participants three times per week by updating them, via e-mail, about the progress made in the discussion.

Attention was given to the size and composition of each group, as suggested by Akers (date unknown) in order to ensure adequate discussion, while keeping the discussion neat and uncluttered. It was decided to include seven participants per discussion group, guided by

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literature related to face-to-face focus groups (DePoy & Gitlin, 1998; Minichiello, Aroni, Timewell & Alexander, 1995) and limited literature related to online focus groups, for example that of Millstead (1998). Two groups, namely a country group and a metropolitan group, were formed to ensure that group members could perceive each other as fundamentally similar (Morgan, 1998).

Stimulus questions for each conference were planned beforehand. These questions were developed to facilitate discussion under each topic and keep the discussion room uncluttered and well structured. The questions were developed in collaboration with a colleague with experience in the use of online conferencing with distance education. Table 9 and Table 10 provide the stimulus questions and structure used for focus group 1, and focus groups 2–5 respectively.

4.8.2.3 Content of a Program aimed at facilitating Change

The first focus group provided feedback to participants on the information obtained from the questionnaire in order to provide further information regarding the results of the questionnaire (refer Chapter 5, Phase 1 for a discussion of the results obtained in this phase). The researcher posted a summary of the results on the website and stimulus questions were posted to facilitate the discussion. Table 9 depicts the content and structure of the first online focus group. During the first focus group discussion, topics were identified for the subsequent four focus group discussions. Five participants actively participated in identifying the topics, which were e-mailed to all participants after the online conference in order to confirm the topics. A further three participants responded to confirm the topics and no contraindications or further suggestions for topics were received.

Table 9 Content and Structure of Online Focus Group 1

Topic of Discussion		Stimulus Question as viewed in the Discussion Room		Reason for Inclusion
Result 1: Limited resources (refer to the following for the corresponding result of the questionnaire: Chapter 5: Pre-intervention Phase: Perceptions regarding resources available for service delivery). Result 2: Understaffing (refer Chapter 5: Pre-intervention Phase: Staffing for the discussion regarding the corresponding result). Result 3: Long waiting lists and services to clients on waiting lists (refer Chapter 5: Pre-intervention Phase: Waiting lists, waiting time and services to clients on waiting lists). Result 4: Insufficient collaboration with school system (refer Chapter 5: Pre-intervention Phase for a discussion regarding the main venues of service delivery).	→	DESCRIPTION OF THE RESULT: "How do you account for these results? Why do services feel that they have inadequate resources? What are the reasons, consequences and context of this result? Please post your response in reply to this question." PAST ACTIONS TAKEN: "From your knowledge and experience, what approaches have been taken to address the issue of inadequate resources in the past? What were the results of these approaches? Please post your response in reply to this question." POSSIBLE STRATEGIES: "What are your thoughts on things that can be done about inadequate resources? Please post your response in reply to this question."	→	To facilitate discussion on describing the reasons, consequences and context of this result. To elicit pre-set indicators (refer this chapter, Table 14). To facilitate discussion around approaches and strategies taken in the past to address this issue. To elicit pre-set indicators (refer this chapter, Table 14). To facilitate discussion around possible future strategies and planning that can be put into place to address this issue. To elicit pre-set indicators (refer this chapter, Table 14).
Identification of future topics.	→	FUTURE TOPICS OF FOCUS GROUPS: "Based on our discussion and the results of the questionnaire, can you make suggestions regarding the topics of subsequent online information sessions?"	→	To identify the topics for focus groups 2–5.
Other related discussion.	→	OTHER DISCUSSION RELATED TO SERVICE DELIVERY MODELS: "Please post your other discussion related to the results and service delivery models in response to this message."	→	To provide the opportunity to discuss issues not covered by the stimulus questions.

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Table 10 Content and Structure of Online Focus Groups 2-5

Structure of Online Focus Groups 2–5, as viewed in the Discussion Room		Reason for Inclusion
QUESTIONS DIRECTED TO SPEAKER: Please insert your questions here which are directed towards the guest speaker.	→	Stimulus for questions to be directed by participants towards the speaker. To provide the opportunity for in-depth discussion of the topic with the speaker.
STRENGTHS OF THE MODEL: "What do you see as the possible strengths of this model?" WEAKNESSES OF THE MODEL: "What do you see as the possible weaknesses of this model?" APPLICATION OF MODEL: "What are your thoughts on the settings and situations in which this model can be applied?"	}	Stimulus questions for discussion regarding the application of the model. To facilitate discussion regarding the topic and elicit pre-set indicators.
OTHER DISCUSSION: "Please insert other related discussion here in reply to this message."	→	Stimulus for other discussion not covered in previous questions.

Focus groups 2–5 were based on these topics and were facilitated by the researcher. These sessions were presented by guest speakers. Guest speakers were either suggested by participants as being clinicians with experience relating to the topic, or by the researcher, after investigation of suitably experienced speakers. Discussion around each topic was facilitated by the researcher. The focus group topics were were: The Maroondah approach; NHS: Occupational Therapy Services for Children and Families; The Hanen Approach and Occupational Therapy in the School System. The content analyses are presented in Appendix O. Table 10 depicts the structure of online focus groups 2–5.

4.9 PROCEDURES UTILISED DURING THIS STUDY

4.9.1 Procedures for the Administration of the Questionnaires

The questionnaires were mailed to the participants with clear instructions on completing them, the required return date, and a self-addressed and paid envelope. In order to avoid the pitfalls of self-administered and mailed questionnaires, specific procedural steps were introduced. These pitfalls include low response rates and inaccurate or incomplete information (Neutens, & Rubinson, 1997; Abramson, 1990). To ensure a high response rate, care was taken to ensure participants' positive attitude towards and understanding of the study. Furthermore, since the study involved a small number of questionnaires, it was possible to follow up on incomplete or incorrect responses. Late returns of questionnaires were also followed up by reminders to return questionnaires. Subsequently, a response rate of 100% was achieved. The post-intervention questionnaire was re-administered eight weeks after the discussion groups were conducted. After a few reminders, a 100% response rate was achieved.

In order to ensure consistent measurements of information (Abramson, 1990; Fink, 1995), the following procedures were adhered to in relation to the measurement instrument: To ensure minimal variations due to the characteristic measured, namely service delivery models, questionnaires were completed within a period of two weeks from the date of mailing

the questionnaires. The post-intervention questionnaire was administered eight weeks after the last online discussion groups. This variation was, however, difficult to minimise due to the different contexts of each organisation and each one's current development phase in terms of change. To address this issue further, the contextual issues for each organisation were identified, described and considered during the analysis of results. In addition, the data collected via the other data collection methods during other phases of the project were considered in conjunction with the data obtained from the questionnaires. The possibility of the occurrence of the Hawthorne effect (whereby the participants' awareness of being tested might influence their responses to questions) was minimised by the initial meeting with the researcher as well as adequate information regarding the project, in order to ensure an understanding of the research aim, as well as a cooperative attitude.

The following procedures were adhered to, ensuring minimal variations due to the person collecting the data. In order to ensure that the researcher maintained objectivity, the researcher presented herself in a friendly, sincere and professional manner, and maintained a neutral viewpoint when she had contact with participants. At the beginning of the data collection period and during this period, the researcher strived, by means of "bracketing", to acknowledge her biases towards this topic by reflecting on it and writing it in a journal (Rose, Beeby & Parker, 1995). These statements were constantly referred to during the process of data collection and analysis. Appendix G provides the application of this technique during the study. Additionally, a journal was used during the planning and execution of the study to document decisions made concerning issues related to methodology and data analysis (Krefting, 1991). An extract of the journal related to decision making regarding the design of the study, is provided in Appendix H.

In order to ensure that the questionnaire measured what it was supposed to measure (Leedy, 1985), and measured it accurately (Fink, 1995b), the following measures were adhered to. To ensure criterion validity, indicators were identified by means of literature

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against which the changes in participants' perceptions were measured. These indicators were based on the literature provided from change management and adult learning literature, as discussed in the previous chapter. A pilot test was conducted to test the questions and determine whether the required information was obtained. In addition, the findings of the questionnaire were compared with other recognised research findings.

4.9.2 Procedures for the Follow-up Interviews

The follow-up interviews were conducted telephonically 16 weeks after the last focus group discussion ended. The following steps were adhered to:

- Appointments were made with participants at a time that was suitable to them.
- Participants received the questions beforehand in order to prepare their responses to the questions, thereby ensuring that the data obtained was rich, accurate and complete.
- During the interviews participants were made aware that the interviews were being taped and each interview lasted between half an hour and one hour.
- In order to elicit in-depth discussion during the interviews, the guidelines provided by DePoy and Gitlin (1998) were used: participants were asked to provide examples of their statements and specific follow-up questions, as well as open-ended questions were asked. Clarification was obtained and follow-up questions were asked until a point of saturation – that is a point at which the researcher had obtained sufficient information for understanding the phenomenon.
- During the interviews, an opportunity was provided for participants to discuss service delivery issues that had not been covered by the stimulus questions and to provide their impressions of the coverage of the phenomenon.
- The participants were thanked for their participation.

When conducting the interviews, the researcher maintained objectivity and a neutral stance, by not providing personal viewpoints during the interviews. During this phase, as

well as the other phases of the project, a clear audit trail was kept by means of journal entries indicating the choices made and steps taken during the planning and execution of the project. A clear description of the procedures followed was documented to ensure that the study is reproducible.

4.9.3 Procedures pertaining to the Online Focus Groups

The following steps were adhered to:

- Participants were reminded of the start of each conference beforehand and received both the stimulus questions for discussion and the guest speakers' presentations by means of an e-mailed message.
- The researcher prepared the discussion room for discussion.
- When participants entered the discussion room, they could clearly distinguish the stimulus questions from other discussions.
- The guest speakers participated in the discussions during the week and answered questions raised by participants.
- The researcher facilitated discussion by participating daily and posting facilitatory questions and statements.
- Participants received e-mailed updates on the discussion.
- A short questionnaire (refer Appendices I and J) was e-mailed to participants after each online conference. It was developed to ensure the validity of the content of focus group discussions and to obtain additional feedback from participants on how they perceived the application of the particular model in their situations.

During the focus group discussions, the researcher maintained a neutral and objective stance and participated by providing unbiased information. The bracketing technique was used before the data collection phase started in order to identify the researcher's bias and

assumptions regarding the topic. These statements were referred to and kept in mind during the analysis of data obtained during this phase.

A record of the audit trail was kept by means of journal entries indicating the choices made and steps taken during the planning and execution of the focus group discussions. A clear description of the procedures followed was documented to ensure that the study is reproducible.

4.10 ANALYTICAL PROCEDURES UTILISED DURING THIS STUDY

4.10.1 Analysis of the Questionnaires

The following procedures were adhered to:

- All responses on the questionnaires were checked to ensure that all the sections were complete and clear. Where responses were unclear or incomplete, clarification was sought from the relevant participant.
- Data was transferred from the participants' response section of the questionnaire to the researcher's coding section, on the right-hand side of each page. This step was double checked to ensure accuracy.
- The data was transferred onto an Excel spreadsheet and double-checked to minimise data-entry errors.
- The data was transferred to the SPS statistical software programme.

Due to the nature of the data – mostly nominal and ordinal – data analysis was by means of descriptive statistical procedures and aimed at describing the current service delivery issues. During the Evaluation Phase, the same procedures were followed for the post-intervention questionnaire and its results were compared with the results of the pre-intervention questionnaire.

4.10.2 Analysis of the Follow-up Interviews

Steps utilised during the analysis of the follow-up interviews are illustrated graphically in Table 11. Two sets of pre-set indicators were utilised to indicate changes in perceptions regarding change in practice (Set 1, refer Table 12), as well as perceptions related to service delivery models employed and principles of best practice (Set 2, refer Table 13).

The first set of indicators indicates evidence of changes in perceptions related to longer-term changes in practice. These indicators refer to the discussion in Chapter 3, The Process of Change, The Elements of Change and the Principles of Adult Learning. The second set of pre-set indicators was measured on three levels: evidence was sought of service delivery models used during Phase 3; evidence of recent changes made to particular service delivery models; and perceptions of best practice that relate to the particular service delivery models. These models relate to literature provided in Chapter 2 regarding current trends in service delivery.

A co-coder coded all the interviews independently from the researcher and in their entirety. The co-coder was a paediatric therapist with research experience. Minimal differences occurred between the analyses of the researcher and those of the co-coder and a 100% consensus was obtained. The bracketing technique was employed before the commencement of the data collection period, which served as reference when data was analysed and interpreted in order to minimise the researcher's subjective interpretation of data.

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Table 11 Data Analysis Procedure employed for Follow-up Interviews

Researcher transcribed the interviews verbatim. ↓	↓
Researcher Procedures: Analysis according to pre-set indicators: 2 sets of indicators (refer Table 12 and Table 15) ↓	Co-coder Procedures: Analysis according to pre-set indicators: 2 sets of indicators (refer Table 12 and Table 15) ↓
Steps in Analysis: For each of the sets of indicators the following steps were utilised respectively: Reading through the transcript and the indicators. Reading through the transcript line by line and allocating the number of the appropriate criterion in the right-hand column. Once finished, the interview was read again, as well as the marked criteria to ensure accuracy and completeness. Critical statements were bolded for follow up later on. ↓	Steps in Analysis: Co-coder performed data-analyses procedures (both sets of indicators), all steps, concurrently with researcher. All transcripts were analysed in their entirety. ↓
Comparison of data analyses done by researcher and co-coder. Discussion on codes that do not correspond. Consensus on variations and changes made to analyses, where appropriate.	

Table 12 Set 1 Pre-Set Indicators for Follow-up Interviews

Indicator	Literature Reference	Further Comments related to Analysis of this Indicator
Evidence of identification of the need for change in current service delivery models.	Cook (1995), Marzalek-Gaucher & Coffey (1991), Berger et al. (1980), Wright (1989), Vestal (1995)	Demonstrated in terminology, such as "more", "increased", "different", and "other ways". References made to the past, i.e. changes already made, or future directed.
Evidence of understanding the nature of the problem: insight into the deficiencies of current models of practice.	Wright (1989), Marzalek-Gaucher & Coffey (1991), Vestal (1995), Bair & Gray (1992), Peters & Tseng (1983), Gravett & Peterson (2000), Jacobs (1999), Knowles (1998)	It includes the identification of positive and negative aspects of current practice.
Evidence of critical reflection regarding current models.	Wright (1989), Marzalek-Gaucher & Coffey (1991), Vestal (1995), Bair & Gray (1992), Peters & Tseng (1983), Gravett & Peterson (2000), Jacobs (1999), Knowles (1998)	Demonstrated behaviour: identification of positive and /or negative aspects of models, together with critical reflection and interpretation.
Evidence of openness to new ideas / alternative strategies and models.	Gravett & Peterson (2000), Peters & Tseng (1983), Marzalek-Gaucher & Coffey (1991), Bailey et al. (1991), Lovelock (1992), Jacobs (1999)	Both evidenced in references to indicate openness to ideas provided by others, as well as participant's own innovative ideas.
Evidence of insight into the need for strategic planning, including the need to analyse external and internal environments of services.	Marzalek-Gaucher & Coffey (1991), Shakleton & Gage (1995)	This includes references to the past or future.
Evidence of internalisation of information: indicate preferences (positive or negative) in terms of information presented.	Walkin (1990)	Statements such as "I like …", "I am in favour of ..." and "I support ..."
Evidence of internalisation of information: indicate the application of information.	Walkin (1990)	Application in specific contexts, but does not need to be application in participant's own setting.
Evidence of internalisation of information: indicate the assessment of different views.	Gravett & Peterson (2000)	Discussion related to the analysis of different viewpoints.
Evidence of internalisation of information: identification of positive and / or negative aspects of the model.	Mezirow (1981)	Does not include the critical interpretation of these aspects.
Evidence of a decision made to negate current views regarding service delivery models.	Gravett & Peterson (2000)	Statements, for example "the need to move away from…"

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Table 12 Continued

Indicator	Literature Reference	Further Comments related to Analysis of this Indicator
Evidence of a synthesis of old and new views.	Gravett & Peterson (2000)	Application of the model in a current setting where the model is modified to fit some aspects of the current model.
Evidence of commitment to change.	Vestal (1995), Bair & Gray (1992), Marzalek-Gaucher & Coffey (1991), Peters & Tseng (1983)	Enthusiasm regarding change; plans made regarding the application in own settings; strategic planning implemented. Terminology such as "more", increase", etc. Included only statements that are future orientated and indicate commitment to change due to the current information that was provided during the focus group discussions.
Actions taken / effort regarding implementation of changes in terms of: Workforce development.	Gravett & Peterson (2000), Marzalek-Gaucher & Coffey (1991), Cook (1995), The Australian Early Intervention Network for Mental Health in Young People (2000)	Statements related to recent plans made in line with work force development in order to implement changes.
Actions taken / effort regarding implementation of changes in terms of: Organisational or procedural development.	Gravett & Peterson (2000), Marzalek-Gaucher & Coffey (1991), Cook (1995), The Australian Early Intervention Network for Mental Health in Young People (2000)	Statements related to recent plans made in line with organisational or procedural development in order to implement change.
Actions taken / effort regarding implementation of changes in terms of: Resource allocation.	Gravett & Peterson (2000), Marzalek-Gaucher & Coffey (1991), Cook (1995), The Australian Early Intervention Network for Mental Health in Young People (2000)	Statements related to recent plans made in line with resource allocation development in order to implement change.
Actions taken / effort regarding implementation of changes in terms of: Development of partnerships and networks.	Gravett & Peterson (2000), Marzalek-Gaucher & Coffey (1991), Cook (1995), The Australian Early Intervention Network for Mental Health in Young People (2000)	Statements related to recent plans made in line with building of partnerships and networks in order to implement change.

Table 13 Set 2 Pre-Set Indicators for Follow-up Interviews

SERVICE DELIVERY MODELS CURRENTLY BEING USED	RECENT CHANGES MADE TO SERVICE DELIVERY MODELS / SERVICE DELIVERY MODELS CONSIDERED FOR CHANGE	PERCEPTIONS REGARDING BEST PRACTICE
Comments related to analysis Focus is on the post-intervention period. Applicable to entire transcript.	**Comments related to analysis** Focus is on changes made to practice, i.e. within the last four months. Applicable to entire transcript.	**Comments related to analysis** Focus is on identifying principles of best practice. Applicable only to question related to best practice principles.

FOR EACH OF THE ABOVE CATEGORIES: IDENTIFY THE FOLLOWING MODELS

Early Prevention and Client Education

Client / Family-Centred Service Delivery

Case Management Model

Direct Service Delivery: One-to-one and Groups

Collaborative Consultation Model

Team Approaches: Multi-disciplinary; Inter-disciplinary and Trans-disciplinary with or without Multi-skilling of Team Members

Use of Support Staff, Multi-skilling and Personnel Substitution (includes Teachers, School Support Officers, etc.)

The Community-based Approach / Community Development

Centre-based versus Home-based Services

Tele-Rehab / Health

Health Promotion / Primary Health Care

Intervention in Functional Environments

4.10.3 Analysis of Data obtained from the Online Focus Groups

Data obtained from the first focus group further complemented the data obtained from the questionnaire regarding the current service delivery models used and issues pertaining to service delivery. During the discussions of the first focus group and focus groups 2–5, data was also obtained to determine the participants' general approach to change and whether learning and change in perceptions were occurring.

The focus group discussions were automatically saved and were printed out immediately after each online conference. Both a content analysis, as well as analysis according to pre-set indicators, occurred. The content analysis of the first focus group discussion (refer Appendix K) was performed according to the following steps, as adapted from Krueger (1994): Reading through the transcript; summarising the information on a separate sheet; looking for links and categories within the summary, and categorising these, if appropriate; reading through the original transcript again and comparing the summary with the transcript.

Summaries of the focus groups' discussions were e-mailed to the participants for their review and feedback and, where required, changes were subsequently made to the transcripts.The summary was e-mailed to the guest speaker and participants for their review and feedback and changes were subsequently made where required.

The analyses according to pre-set indicators were conducted by means of the same procedure as for the interviews: reading through all the indicators, reading the original transcript and looking for evidence of these indicators, marking the corresponding indicators in the right- hand margin of the transcript, reading the transcript again, and revising, where required. One entry on the website could have more than one statement providing evidence of indicators. The researcher, as well as an independent coder, analysed the transcripts in their entirety. The coded transcripts were compared after each independent analysis, variations in

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coding were discussed, and changes were made, where appropriate. Minimal differences in coding occurred and a 100% consensus was achieved.

The pre-set indicators were discussed in Chapter 3 (The Principles of Organisational Change, the Elements of Change and the Principles of Adult Learning) and are illustrated in Table 14. The indicators for focus group 1 concentrated on the initial stages of the problem-solving process and related to information shared regarding current practice. Table 15 indicates the pre-set indicators for focus groups 2–5. The bracketing technique was used before the data collection phase started in order to identify the researcher's bias and assumptions regarding the topic. These statements were referred to and kept in mind during data analysis and interpretation. In addition, the short questionnaires were analysed according to descriptive statistical procedures.

4.11 SUMMARY OF CHAPTER

This discussion of the data-analysis procedures concludes this chapter, which provides a detailed layout of the research design and methodologies utilised in this study. The chapter lays the foundation for the execution of the study and for the results that were obtained. The results and findings are discussed in the next chapter.

Table 14 Pre-set Indicators for Focus Group 1

Indicator	Literature Reference	Further Comments related to Analysis of this Indicator
Evidence of identification of problems related to current service delivery models.	Bair & Gray (1992)	Discussion related to specific problems.
Evidence of identification of the need for change in current service delivery models.	Cook (1995), Marzalek-Gaucher & Coffey (1991), Berger et al. (1980), Wright (1989), Vestal (1995)	Demonstrated in terminology such as "more", "increased", "different", and "other ways". References to the past included, i.e. changes already made or future directed.
Evidence of understanding the nature of the problem: insight into the deficiencies of current models of practice.	Wright (1989), Marzalek-Gaucher & Coffey (1991), Vestal (1995), Bair & Gray (1992), Peters & Tseng (1983), Gravett & Peterson (2000), Jacobs (1999), Knowles (1998)	It includes the identification of positive and negative aspects of current practice.
Evidence of critical reflection regarding current models.	Wright (1989), Marzalek-Gaucher & Coffey (1991), Vestal (1995), Bair & Gray (1992), Peters & Tseng (1983), Gravett & Peterson (2000), Jacobs (1999), Knowles (1998)	Demonstrated behaviour: identification of positive and / or negative aspects of models, together with critical reflection and interpretation.
Evidence of openness to new ideas / alternative strategies and models.	Gravett & Peterson (2000), Peters & Tseng (1983), Marzalek-Gaucher & Coffey (1991), Bailey et al. (1991), Lovelock (1992), Jacobs (1999)	Both evidenced in references to indicate openness to ideas provided by others, as well as participant's own innovative ideas.
Evidence of insight into the need for strategic planning, including the need to analyse external and internal environments of services.	Marzalek-Gaucher & Coffey (1991), Shakleton & Gage (1995)	This includes references to the past or future.
Motivation to learn, interest in information and attention given.	Walkin (1990)	Statements made which indicate keenness to learn, that they are interested in the information and that they are paying attention to the information.
Active participation in discussion.	Walkin (1990)	Demonstrated behaviour: interaction between participants; reference to another message, the number of entries.

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Table 15 Pre-set Indicators for Focus Groups 2–5

Indicator	Literature Reference	Further Comments related to Analysis of this Indicator
Evidence of critical reflection regarding current models.	Wright (1989), Marzalek-Gaucher & Coffey (1991), Vestal (1995), Bair & Gray (1992), Peters & Tseng (1983), Gravett & Peterson (2000), Jacobs (1999), Knowles (1998)	Demonstrated behaviour: identifying positive and / or negative aspects of models, together with critical reflection and interpretation.
Evidence of openness to new ideas / alternative strategies and models.	Gravett & Peterson (2000), Peters & Tseng (1983), Marzalek-Gaucher & Coffey (1991), Bailey et al. (1991), Lovelock (1992), Jacobs (1999)	Both evidenced in references to indicate openness to ideas provided by others, as well as the presentation of the participant's own innovative ideas.
Evidence of internalisation of information: indicate preferences (positive or negative) in terms of information presented.	Walkin (1990)	Statements such as "I like…", "I am in favour of..." and "I support..."
Evidence of internalisation of information: indicate the application of information.	Walkin (1990)	Application in specific contexts, but does not need to be application in participant's own setting.
Evidence of internalisation of information: indicate the assessment of different views.	Gravett & Peterson (2000)	Discussion related to the analysis of different viewpoints.
Evidence of internalisation of information: identification of positive and / or negative aspects of the model.	Mezirow (1981)	Does not include the critical interpretation of these aspects.
Motivation to learn, interest in information and attention given.	Walkin (1990)	Includes specific questions directed at guest speaker.
Evidence of a decision made to negate current views regarding service delivery models.	Gravett & Peterson (2000)	Statements, for example "the need to move away from…"
Evidence of a synthesis of old and new views.	Gravett & Peterson (2000)	Application of the model in a current setting where the model is modified to fit some aspects of the current model.
Active participation in discussion.	Walkin (1990)	Demonstrated behaviour: interaction between participants; reference to another message; the number of entries.
Evidence of commitment to change.	Vestal (1995), Bair & Gray (1992), Marzalek-Gaucher & Coffey (1991), Peters & Tseng (1983)	Enthusiasm regarding change; plans made regarding the application in own settings; strategic planning implemented. Terminology such as "more", increase", etc. Only statements included that are future orientated and indicate commitment to change due to the current information that has been provided during the focus group discussions.

5 PRESENTATION AND DISCUSSION OF RESULTS

In this chapter the results and findings of the study are presented in the following format:

- **The Pre-intervention Phase:** Firstly, the application of the data collection tools, namely the pre-intervention questionnaire and the first online focus group, is discussed. The data is then presented and discussed in a consolidated form as obtained from both these tools. The data relates to: the nature of services provided; the strategies employed to deliver services; participants' perceptions related to the strategies employed; a description of the management of services, and participants' approaches to change. Lastly, the results of the short questionnaires indicating the participants' evaluation of the first online focus group, are discussed.
- **The Intervention Phase:** Findings from this phase are discussed as it relates to the application of the data collection tool, i.e. the second to fifth online focus groups, followed by a discussion of the data obtained. Data from this phase aimed to describe managers' approaches to change. Lastly, the results obtained from the short questionnaires indicating the participants' evaluation of the second to fifth focus groups, are discussed.
- **Evaluation Phase:** The application of the post-intervention questionnaire and the follow-up interviews are discussed, followed by the consolidated results and findings obtained from both these tools. The data relates to comparisons with participants' perceptions of aspects of service delivery both before and after the Intervention Phase; their approach to change in this phase, as well as their perceptions of recent changes in practice. The section also includes participants' perceptions regarding principles of best practice in early intervention service delivery and concludes with findings related to participants' evaluation of the project.

5.1 PHASE 1: PRE-INTERVENTION PHASE

Managers of 14 occupational therapy early intervention services in South Australia participated in the study. The Pre-intervention Phase consisted of the administration of the pre-intervention questionnaire and the use of an online focus group in order to establish current trends in service delivery.

5.1.1 Application of the Research Tools

5.1.1.1 The Pre-intervention Questionnaire

Having sent the questionnaire to the 14 participants, a 100% response rate was achieved. The data obtained is divided into the following four categories: the nature of the services provided by the participating organisations; a description of the strategies employed to deliver services; participants' perceptions related to the strategies employed; and a description of the management of the participating services.

5.1.1.2 The First Online Focus Group

The first online focus group was structured to provide feedback to participants on the information obtained from the questionnaire and provided a forum for discussion of these results. Data obtained from the focus group provided further information about the current status of service delivery. In addition, data analysis procedures were employed to obtain information regarding managers' approaches to change.

Two online focus group discussions occurred simultaneously: that of the country group and that of the metropolitan group. The metropolitan group consisted of seven participants and the country group had six. The country group was more active and provided a total of 70 entries on the website. The metropolitan group provided 29 entries. Participation occurred predominantly during standard office hours. Participants had a week to participate in the discussion (refer Chapter 4 for details regarding the procedures of the online focus groups). Table 9 in Chapter 4 provides a detailed layout of the content and structure of the

first focus group discussion. The topics included: Limited Resources; Understaffing; Long Waiting Lists; and Insufficient Collaboration with the School System.

5.1.2 Presentation of Consolidated Results and Findings

5.1.2.1 The Nature of the Services Provided

The questionnaire included questions to obtain descriptive and contextual data related to the types of services delivered. Table 16 illustrates the services provided (see Appendix C for the questionnaire, which includes the definitions of the terminology used). This data provides an overview of the main focus of services – it illustrates that the participating services provide a wide variety of services. Due to the small number of participants in the study, both the percentages and the actual number of respondents are provided.

Table 16 Services provided by Respondents

Services Provided	Number of Respondents	Percentage
Habilitation	14	100
Remediation	11	79
Rehabilitation	10	71
Prevention	10	71
Social Integration	10	71
Health promotion	9	64
N=14		

Table 16 illustrates that the majority of services view the focus of their services as being on intensive training or re-training of skills, i.e. habilitation and remediation. Usually applied one-to-one, or in small groups, due to their individualised and intensive nature, these frameworks are commonly being used amongst occupational therapists (Hagedorn, 1997). This result correlates well with the main client group identified (i.e. clients with development delays and scholastic difficulties - refer Table 17), being one of the main service options for this client group.

Prevention and social integration were indicated by 10 of the 14 services and were indicated in Chapter 2 as two of the international trends in early intervention service delivery. This result indicates that a large proportion of the services perceive themselves to be playing a role in the delivery of services related to the principles of prevention: client education, early detection and intervention, as well as the social integration of clients into their natural settings.

Health promotion featured last as a type of service delivered, but still featured strongly in relation to the number of participants (9 of the 14 services). Of interest is that although traditional service types still featured the strongest, a large proportion of the services viewed themselves as delivering services that correlated with international trends, i.e. health promotion, social integration and prevention.

5.1.2.1.1 Client Types

The second question that provides data on the nature of services provided, relates to client-orientated types of services. It was recommended in Chapter 2 (Figure 1: Factors Influencing the Service Delivery Process) that this aspect of service delivery be included in an internal assessment when considering the appropriateness of service delivery models. Table 17 illustrates the main areas of practice related to client groups (refer Appendix C for the questionnaire, which includes the definitions of terminology used). Since it was established that there is an overlap between categories, participants were asked, in the instruction section of the questionnaire, to identify the categories that best describe their services. The terminology was chosen due to its wide application in the classification of client groups in occupational therapy practice.

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Table 17 Main Areas of Practice: Client Type

Main Area of Practice	Number of Services (More than One Choice per Participant)	Percentage
Development delays and scholastic difficulties	14	100
Cognitive / intellectual impairment	8	57
Neurological impairment	7	50
Physical impairment	7	50
Psychiatric impairment	1	7
Medical / surgical	1	7
Medico-legal	1	7
N=14		

Participants had more than one choice in answering this question. Responses ranged from: 14 indicating services to children with development delays and scholastic difficulties; 8 indicating cognitive / intellectual impairment; and 7 indicating physical and neurological impairments. Services to children with psychiatric impairment, medical / surgical conditions and medico-legal cases were less prevalent, with 1 response each. The low prevalence of services to children with psychiatric impairments is of interest and may be due to the fact that these services are included in other services. For example, services to clients with Attention Deficit Disorder may fall under other broader and overlapping categories such as "neurological impairment" or "developmental delays and scholastic difficulties". It may also indicate that occupational therapy services to this client group are not adequate and the result may warrant further investigation. The result may also indicate a correlation with the findings of the National Survey of Mental Health and Wellbeing (Woolbridge, 2000), discussed in Chapter 2, Mental Health Services, regarding the limited number of young people with mental health disorders who receive professional help. Further correlations with other service delivery aspects will be made in later sections of this chapter.

5.1.2.1.2 Geographical Area covered by Service

Participants represented services in the Adelaide metropolitan area, as well as urban, rural and remote areas in South Australia. Participants had more than one choice in this area. Data indicated that the majority of the services cover both urban and rural areas (9 of the 14 respectively), which include services to towns in regional areas. Metropolitan areas were covered by the second largest proportion of services (7 of the 14 participants), which include services in city areas. Remote areas are covered by the third largest number of services (5 of the 14 participants) and include areas of low density, which are geographically isolated. Most services cover areas of more than 100 kilometres (8 of the 14 participants) with two each covering 15–30 kilometres, 30–50 kilometres, and 50–100 kilometres respectively. This result is discussed in more detail later in this chapter.

5.1.2.2 The Strategies employed to deliver Services

Figure 1 in Chapter 2 provided the background for incorporating questions related to the service delivery system that need to be taken into account when considering appropriate service delivery models. Questions were included to provide data on aspects of services that relate to: the strategies employed by services, including the occupational therapy approaches and models used; the service delivery models employed; staffing and staffing strategies; the use of waiting lists; and the main venues of service delivery. These aspects formed the basis of understanding the internal factors influencing service delivery, including problematic issues.

5.1.2.2.1 Occupational Therapy Approaches and Models used

Table 18 depicts the occupational therapy approaches and models used (refer Appendix C for the questionnaire, which includes the definitions of terminology used).

The occupational therapy approaches / models most commonly used by the services were (in order of prevalence): sensory integration, the neuro-development approach, the

family-centred approach, and group work. Table 19 presents extracts from Cross Tabulations between client type (clients with development delays and scholastic difficulties) and occupational therapy approaches / models used. The models with the highest associations are presented. Participants had more than one choice in both these categories.

Table 18 Occupational Therapy Approaches and Models used in Practice

Approach / Model used	Number of Services (More than one Choice per Participant)	Percentage
Sensory integration	12	100
Neuro-development approach	11	79
Family-centred approach	11	79
Group work	10	71
Biomechanical approach	8	57
Behaviour modification	8	57
Rehabilitative approach	8	57
Client-centred approach	8	57
Cognitive-perceptual approach	7	50
Community-based approach	6	42
Canadian occupational performance model	5	35
Cognitive disability model	4	28
Activity therapy	3	21
Assistive technology	2	14
N=14		

Table 19 suggests that all the approaches mentioned previously are often used in service delivery to children with development delays and scholastic difficulties, since they are the main client group (refer to the result in Table 17). The literature supports the use of these models with this client group (Stephens & Tauber, 1996; Clark, Maillloux & Parham, 1989). Noteworthy is the intensive and specialised nature of the application of sensory integration and neuro-development intervention (Clark, Maillloux & Parham, 1989). Further discussion relating to these results follows later in this chapter.

Table 19 Cross Tabulation: Clients with Development Delays and Scholastic Difficulties by Occupational Therapy Approaches / Models used

	Sensory Integration	Neuro-development	Family-centred	Groups
Clients with development delays and scholastic difficulties	86%	79%	79%	71%
N=14				

The community-based approach was used by fewer than half of the respondents (refer Table 18). Services that used the Canadian Occupational Performance Model, the cognitive disability model, activity therapy, and assistive technology, were in the minority. Noteworthy is the use of the family-centred, group work and client-centred approaches by more than half of the respondents. These three approaches correspond with some of the current international trends in early intervention service delivery, as discussed in Chapter 2, while the limited use of the community-based model did not correspond with the international trend in the use of this model.

5.1.2.2.2 Service Delivery Models employed

Table 20 indicates the results of this section (refer Appendix C for the definitions of the terminology used). Respondents had a choice of more than one response. As discussed previously, it was established that there is an overlap between categories, and participants were asked to indicate the categories that describe their services best. In addition, when considering these results, it should be taken into account that qualitative data indicates that participants interpret certain terminology associated with service delivery models differently. Even within the given boundaries and guidelines provided in the definitions of these terms, perceptions vary regarding the application of these service delivery models. The team approaches, and the consultation and case management models in particular have been found to differ as regards to the interpretation of services. The difficulties in distinguishing between team approaches have been documented in the literature, for example Bird (1990) illustrates the team approaches on a continuum rather than as discrete and separate entities. In addition,

negative connotations seem to exist regarding the use of certain terminology. For example, while many services described the use of informal case management and consultation models during the focus group discussions and interviews, services do not indicate that they are using it, or that they are considering using it, due to negative perceptions which seem to exist amongst clinicians regarding these models.

Table 20 Service Delivery Models currently employed by Services

Service Delivery Model	Number of Services (More than One Choice per Participant)	Percentage
Consultation	14	100
Groups	13	93
Monitoring	12	86
Direct, one-to-one	12	86
Inter-disciplinary	11	79
Multi-disciplinary	6	43
Trans-disciplinary	6	43
Case management	4	29
N=14		

Participants indicated that the most prevalent model used was consultation, which was used by all services. Next, groups were used most commonly, followed by the monitoring and direct, one-to-one service delivery models, and fourthly, the inter-disciplinary model. These models are supported by the literature as being appropriate for paediatric service delivery (Case-Smith, Allen & Pratt, 1996; Dunn, 1988). Fewer than half of the respondents indicated that their services used the multi-disciplinary, trans-disciplinary and lastly, the case management models. Noteworthy is that the traditional models of direct, one-to-one and group work feature strongly, with lesser emphasis on the team-based models as well as the case management model.

The use of the direct, one-to-one model and the group models correspond with the only other documented Australian paediatric service delivery survey in occupational therapy.

In the study of Rodger, Springfield & Maas, documented in two publications (Rodger, Springfield & Maas, 1993; Springfield, Rodger & Maas, 1993), respondents indicate the use of these models as being used most frequently amongst other models. Participants wished to maintain these intervention models. These results suggest that therapists value the principles of individualisation and intensity of intervention, which these models offer. As mentioned in Chapter 2, the National Research Council and Institute of Medicine (2000) supports the use of individualised, well-designed and -implemented programs. These results correspond with the intensive nature of services suggested in the use of the habilitation, remediation, sensory integration, and neuro-development frameworks. The average number of models indicated by the participating services was six, with a range from eight models used by one service to three models used by two services. This may indicate the complex nature of service delivery within these services.

Table 21 illustrates extracts from Cross Tabulations between service delivery models employed and occupational therapy approaches / models utilised. The service delivery models with the highest association with occupational therapy approaches / models are presented. Participants had more than one choice in both these categories. The table illustrates the use of the consultation model with sensory integration and family-centred models. These results indicate the inclusion of families in the consultation process and that therapists find the application of sensory integration principles to be appropriate within a consultation model. It further illustrates the use of the monitoring models and the direct, one-to-one model with the neuro-developmental and sensory integration approaches. This illustrates the specialised nature of these approaches and that monitoring of these applications is required, as described by Clark, Maillloux and Parham (1989) and Dunn (1988).

Table 21 Cross Tabulations: Service Delivery Models employed by Occupational Therapy Models / Approaches used

	Sensory Integration	Neuro-development	Family Centred
Consultation model	86%	79%	79%
Monitoring model	92%	92%	75%
Direct, one-to-one model	92%	92%	75%
N=14			

5.1.2.2.3 Staffing

In further informing the description of the internal factors related to the service system that influence service delivery, questions were included with regard to the number of occupational therapists employed; the number of Full-time Equivalents per service; the client-therapist ratios, and the staffing strategies employed. Table 22 depicts the Full-time Equivalents and the number of occupational therapists employed.

Table 22 Full-Time Equivalents of Occupational Therapists and Number of Occupational Therapists employed

Respondent	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Number of occupational therapists employed	1	30	2	3	4	2	1	1	1	1	3	8	1	1
Full- time equivalents (1= Full Time)	1	9.8	1.8	1.9	4	1.7	0.5	0.4	1	0.5	2.5	5.7	1.8	0.7
N=14														

The average number of occupational therapists employed by the services was 4, ranging from 30 therapists employed by 1 service to 6 services having 1 therapist each.

Occupational therapy assistants were utilised by 12 of the 14 services. Noteworthy is the fact

that half of the respondents are sole therapists who are responsible for service delivery in paediatrics.

The total number of Full-time Equivalents indicates that 6 of the 14 services have a therapist or therapists working full time or less. In the comments section of this question, 7 of the 14 services mentioned that understaffing was a consequence of their limited resources. Four services indicated a lack of time and 2 indicated heavy workloads as problematic issues. This result suggests that problematic issues impact on service delivery, especially when considering the result related to client–therapist ratios. The majority of services (12 out of the 14, which is 86%) have a client–therapist ratio of more than 25 clients per therapist. One service indicated a ratio of 12 to 25 clients per therapist, and another a ratio of fewer than 12 clients per therapist. This indicates that, for a large proportion of these services, therapists have caseloads of more than 25 clients per therapist. When determining caseload sizes, many variables need to be considered (Johnson, 1996), one of which is the service delivery model employed. Due to the many models that services are using in combination, no direct interpretation can be made regarding this result. The high number of respondents indicating the highest ratio is however, noteworthy, especially when considering the number of services without full-time therapists. No concrete measurements in the literature have been found against which these results may be compared.

Table 23 presents extracts from Cross Tabulations between client–therapist ratio (particularly more than 25 per therapist) and service delivery models used. The service delivery models with the highest association with the ratio are presented. Participants had more than one choice when selecting service delivery models. The table indicates an association between a client–therapist ratio of more than 25 clients per therapist and the group and consultation models, suggesting that this ratio is frequently encountered in these models.

Table 23 Cross Tabulation: Client –Therapist Ratio of more than 25 per Therapist by Group and Consultation Models

	Group Model	Consultation Model
Client–therapist ratio of more than 25 clients per therapist.	94%	86%
N=14		

In order to obtain a description of the current staffing strategies that services have implemented and are using, and in light of problematic issues related to staffing shortages, participants were asked whether they were currently using certain staffing strategies. Participants were also asked whether they would consider using such strategies in the future (refer Appendix C for definitions of the terminology used). Table 24 illustrates the responses to this question.

Table 24 Number of Participants indicating the current Use of Staffing Strategies and Consideration of the Use of Staffing Strategies in the Future

Staffing Strategy	Current Use: Yes	Current Use: No	Current Use: Unsure	Total	Would conside using: Yes	Would consider using: No	Would consider using: Unsure	Total
Personnel substitution	7 (50%)	6 (43%)	1 (7%)	14 (100%)	8 (58%)	3 (21%)	3 (21%)	14 (100%)
Therapy assistants	5 (36%)	9 (64%)	0 (0%)	14 (100%)	13 (93%)	0 (0%)	1 (7%)	14 (100%)
Multi-skilling of support staff	5 (36%)	9 (64%)	0 (0%)	14 (100%)	11 (79%)	3 (21%)	0 (0%)	14 (100%)
Multi-skilling of therapists	12 (86%)	2 (14%)	0 (0%)	14 (100%)	14 (100%)	0 (0%)	0 (0%)	14 (100%)

The majority of respondents indicated that they were currently using multi-skilling of therapists. When this response is compared with the number of participants who utilise the inter-disciplinary team approach (i.e. 11 of the 14 participants), it may indicate confusion in the application of the terminology of the team approaches. Multi-skilling is more applicable to the trans-disciplinary approach (Springfield, Rodger & Maas, 1993), which did not feature

strongly (6 of the 14 participants indicated the use of the trans-disciplinary approach – refer Table 20).

Half of the respondents indicated that they were using personnel substitution and five that they were using multi-skilling of support staff. All participants indicated that they would consider multi-skilling of their therapists in the future, which may indicate an increased use of the trans-disciplinary model in the future. Most respondents indicated that they would consider the use of personnel substitution, therapy assistants and multi-skilling of support staff. This result indicates openness to the application of these strategies.

5.1.2.2.4 Waiting Lists, Waiting Time and Services to Clients on Waiting Lists

A further category of questions related to waiting lists was included in order to obtain a better picture of the factors impacting on service delivery. Ten of the 14 respondents indicated that they had waiting lists, while 8 of the 10 were not providing services to clients on the waiting list. The average waiting time for an assessment is 93 days (with the longest waiting time being 200 days, and the shortest being 7 days), while the average waiting time for intervention is 110 days. Eight out of the 10 respondents indicated that they felt that services to clients on waiting lists were inadequate. Rodger, Springfield and Maas (1993) found the average waiting time for intervention to be 4 weeks, while this study has found an average waiting time of 110 days (22 working weeks), which is significantly higher than that in the Rodger, Springfield and Maas survey. These results suggest problematic issues related to service delivery with regard to waiting lists for services.

5.1.2.2.5 Main Venues of Service Delivery

Respondents were asked to indicate the percentage of services delivered at various venues. Fourteen participants completed this question, and indicated that most of their services were delivered at organisations' home bases (an average of 49%), followed by 25% that were delivered at educational facilities. Fourteen percent of the services were delivered in clients' homes, 8 % at organisations' satellite facilities, and 4% at community facilities.

Considering the question relating to the geographical area covered, in which 8 of the 14 respondents (57%) indicated an area in excess of 100 kilometres, it indicates that, on average, 49% of services provided by the organisations are structured to have clients travel to the home base of the organisation, rather than delivering services at settings closer to the client. It also indicates that most intervention (49% plus 8%, totalling 57%) occurs in clinical settings, i.e. at home bases and satellite facilities, rather than in the natural environment of the client. Intervention in natural environments was identified as an international trend in Chapter 2 and its use is advocated by various authors, such as Peck (1993), Wolery and Fleming (1993), Dunn (2000) and Gallagher (2000). This result correlates with the result in which fewer than half of the respondents (6 of the 14) indicated the use of the community-based approach. In addition, services indicated qualitatively during the questionnaire a desire to strengthen collaboration with the school system. Four of the respondents felt that collaboration with the school system was insufficient.

5.1.2.3 Perceptions regarding Service Delivery Aspects

In addition, participants were asked to indicate their perceptions regarding: the effectiveness of current service delivery models and resources; the need for change in the service delivery models employed; and the perceived difficulty in facilitating change.

5.1.2.3.1 Perceptions regarding Resources available for Service Delivery

The majority of respondents (86%, or 12 of the 14 participants) indicated that they perceived their resources to be inadequate, with 14% (2 of the 14 participants) indicating that they were adequate. Participants' comments included reference to limited financial and human resources, resulting in staff shortages, and limited new developments and resources for school visits. This result corresponds with the results of the study by Rodger, Springfield and Maas (1993), conducted in Queensland, Australia. It seems that limited resources for service delivery is an ongoing problem, also occurring in other states. This result suggests a problematic issue that impacts on service delivery.

5.1.2.3.2 Perceptions regarding the effective Use of Venues

Half of the 14 respondents indicated that they felt that their venues were effective and adequate, while the other half did not consider their venues to be effective. This result warrants further investigation, especially in view of the previous result, which is related to the limited use of the community-based approach, and the fact that most services are delivered in clinical settings. The result does indicate a half-half split in perceptions regarding this aspect of service delivery.

5.1.2.3.3 Perceptions regarding the effectiveness and adequacy of the Models

The majority of respondents (50%, or 7 of the 14 participants) indicated that they felt that the current service delivery models were effective and adequate, while 14 % (2 participants) were unsure. 36% (5 participants) felt that the service delivery models were inadequate and ineffective. This combined percentage (those unsure and those feeling that the service delivery models were inadequate), totalling half of the respondents, is noteworthy and suggests that further exploration of this issue is warranted. Of the 36% who felt that the service delivery models were inadequate, 4 of the 5 indicated a preference to use the inter-disciplinary and trans-disciplinary models more frequently.

5.1.2.3.4 Perceptions regarding the Need for Change in Service Delivery Models employed, and the perceived Difficulty in facilitating Change

Half of the respondents (7 of the 14 participants) indicated that they perceived a need for change, with 7% (1 participant) being unsure and 43% (6 participants) indicating that they did not perceive a need for change (the total number of respondents being 14). As mentioned before, half of the respondents indicated that they perceived current service delivery models to be effective and adequate, with 14% being unsure.

These seemingly contradictory results need to be interpreted with some caution since these perceptions were measured with close-ended questions and leave some room for differences of interpretation. In addition to this, the terms "effectiveness", "adequacy" and

"change" are difficult to define and capture in a questionnaire. For example, some respondents may have interpreted the term as referring to major changes, while others may perceive it as referring to minor modifications to current ways of service delivery. These contradictory results may also indicate that participants have not fully explored these issues yet and may therefore respond to the two questions in a contradictory manner.

Of the 50% who indicated a need for change, 57% (4 of the 7 participants) foresaw difficulties in facilitating change. The area of difficulty that was most prevalent was in mobilising resources for action, followed by the ability of their upper management to see the need for change, and the ability of personnel to see the need for change. One service indicated that it foresaw difficulties in developing an action plan to meet its needs.

5.1.2.4 Description of Occupational Therapy Management and Management Style

Aspects related to the management of a service were discussed and are illustrated in Figure 1 (Chapter 2) and in Chapter 3, as being essential service elements that require consideration when services are considering changes to their service delivery models. Questions were included to elicit data pertaining to managers' time division; perceptions regarding management style; management training; perceptions regarding comfort in dealing with management tasks; and current management practices used. Responses to this section of the questionnaire varied, and not all 14 participants completed all the questions in this section. This is due to the varying structures of the services that were discussed in Chapter 3, Sampling Method. Although these therapists had senior and coordinating positions, some of the therapists who were not formally appointed as managers, did not feel comfortable to complete the management section.

5.1.2.4.1 Perceptions regarding Management Styles

Management styles that impact on effective change management in organisations were identified from the literature. Perceptions of respondents regarding their current

management styles were obtained by indicating, on a scale, their identification with each management style. Table 25 depicts their identification with each style. Eleven managers completed this section.

Table 25 Managers' Identification with Management Styles

Management Style	1: Strong Identification	2: Moderate Identification	3: Do not identify with Style
Predicting problems and developing strategies to prevent the problems from occurring	2 (18%)	9 (82%)	0 (0%)
Tendency to mostly react on and address problems that have occurred	1 (10%)	5 (45%)	5 (45%)
Tendency of manager to make most decisions at the management level; close supervision of personnel	0 (0%)	3 (27%)	8 (73%)
Tendency to involve personnel in decision-making processes, provides more freedom to personnel	9 (82%)	2 (18%)	0 (0%)
Focus on external changes and trends that influence services of the department, has a network of external contacts	4 (36%)	7 (64%)	0 (0%)
Focus on internal trends and changes in the department	4 (36%)	7 (64%)	0 (0%)
N=11			

Table 25 illustrates that the strongest identification was with the tendency to involve personnel in the decision-making process and provide freedom to personnel, i.e. a participative management style. Managers had a moderate identification with predicting problems, with focusing on external changes, and with focusing on internal trends. The strongest style with which they did not identify, was the tendency of the manager to make most decisions at the management level, i.e. a more authoritarian style. This result illustrates that managers identify strongly with the participatory management approach, which is very relevant when facilitating effective change (Marzalek-Gaucher & Coffey, 1991; Cope, 1981).

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5.1.2.4.2 Management Training and Perceptions regarding Comfort with Management Tasks

The majority of managers (8 of the 13) did not have any training in management to assist them with their managerial duties, with 5 indicating that they did have training. Nine of the 14 indicated that they saw a need for further training in management, with 1 indicating no need for this, and 4 being unsure. Marzalek-Gaucher and Coffey (1991) indicate that commitment to training is one of the characteristics of change leaders. These results indicate an important need for management training within the occupational therapy profession, and a weakness in the readiness of managers to manage processes of change in their organisations. The results indicate that managers have an insight into their need for training.

Management tasks that relate to change management were identified from the literature and managers were asked how comfortable they felt with the different tasks. They were asked to indicate their level of comfort on a four-point scale. Table 26 indicates their comfort levels in relation to the different management tasks. Twelve participants completed this question.

Managers felt most comfortable with being innovative and facilitating change. This result indicates a sound base for facilitating change. They felt least comfortable with financial planning, indicating an area in which managers may require support. Other areas related to the implementation of change. Areas with which managers felt somewhat comfortable, are conflict management, negotiation, and the delegation of work. Strategic management and involvement in higher management ranged from "not comfortable" to "comfortable". These results suggest that while managers are comfortable with initiating processes of change by being innovative, they feel less comfortable regarding other aspects of implementing changes in the areas mentioned.

Table 26 Comfort Levels of Managers in relation to Management Tasks

Management Task	1: Not comfortable	2: Somewhat comfortable	3: Comfortable	4: Unsure
Conflict management	1 (8%)	8 (67%)	2 (17%)	1 (8%)
Negotiation	1 (8%)	8 (67%)	2 (17%)	1 (8%)
Financial Planning	5 (41%)	5 (42%)	2 (18%)	0 (0%)
Strategic Management	2 (17%)	4 (34%)	5 (41%)	1 (8%)
Facilitating Change	1 (8%)	4 (34%)	7 (58%)	0 (0%)
Delegating work	0 (0%)	7 (58%)	5 (42%)	0 (0%)
Being innovative	1 (8%)	1 (8%)	10 (84%)	0 (0%)
Involvement in higher management	2 (17%)	5 (42%)	5 (42%)	0 (0%)
N=12				

5.1.2.4.3 Current Management Practices used

Most departments (11 of the 14) functioned within a framework of a business or strategic plan and 8 employed strategic analysis, for example a SWOT analysis. Eleven operated according to a mission and goal. It was not clearly stated whether a distinction was made between the goals of the organisation and those of the department. In addition, 11 of the 14 regularly assessed the effectiveness of their service delivery, and all of them indicated that they included the input of clients in their service assessments. Eight of the 11 respondents included the input of referring agencies and 5 included the input of staff in the service assessments. Again, it was not clear whether occupational therapy services were included under each organisation's assessment procedures, or whether the services had their own

assessment procedures. According to Marzalek-Gaucher and Coffey (1991), and Vestal (1995), these are important organisational factors that impact on the effectiveness of change. These results suggest that the services have some service assessment, planning and goal-setting processes in place, which may serve to facilitate the process of change.

Managers were asked how much time they spent on certain management tasks and, in a separate question, how important each of the management tasks on which they spent their time, was. The data in Table 27 indicates the responses to the question relating to the actual time spent on management tasks and the respondents' perceptions of the importance of these tasks (ranging from 1 – "Not Important" to 7 – "Important"). The total rating for the perceived importance of the task was calculated as the total of the "Important" category (4 to 6 on the scale). The total rating for "Not Important" was obtained by totalling the "Not Important" category (1 to 3 on the scale).

Perceptions were divided regarding the importance of controlling. Results indicate that with some tasks, managers' time allocation corresponded well with their ratings according to the importance of the tasks. Managers devoted most of their time to planning and also rated it as the most important task. They devoted second most time on organisation and also perceived it to be the second most important, together with external relations, although they spent only 11% of their time on external relations. Monitoring the environment was perceived as being important (fourth in the order of importance), with 2% of time actually being spent on it.

Table 27 Actual Time spent on Management Tasks compared with perceived Importance of Tasks

Management Task	Actual Time spent (Percentage)	Rating according to Actual Time spent	Total for "Important"	Total for "Not important"	Rating according to Importance
Planning	32	1	12	0	1
Organisation	27	2	11	1	2
Leading	8	5	8	4	4
Controlling	6	6	5	7	5
Human resource management	14	3	9	2	3
External relations	11	4	11	1	2
Monitoring the environment	2 Total = 100%	7	8	4	4
N=12					

These results indicate that even though services indicated that they utilised strategic plans (as discussed previously in this section), managers did not spend a significant amount of time on monitoring the environment or building external relationships. Although managers indicated that they perceived these tasks to be important, they spent most of their time on clinical work, planning and organisation. Tasks related to keeping track of external changes are important in the process of change (Marzalek-Gaucher & Coffey, 1991; Bailey et al., 1991) and indicate that managers do not spend adequate time on these tasks.

5.1.2.5 Services' Approaches to Change

Table 28 illustrates the data obtained from the analysis of data provided by the first online focus group. It indicates the pre-set indicators, with the number of focus group statements that are identified for each indicator. Evidencing statements for each indicator are provided in Appendix L.

Table 28 Indicators and Number of corresponding Focus Group Statements with Evidence of each Indicator

Indicators	Total Number of Statements of both Country and Metropolitan Groups	Rank in Order of Prevalence (1 – most, to 6 -- least)
Critical reflection regarding current models.	45	1
Identification of the need for change in current service delivery models.	32	2
Identification of problems related to current service delivery models.	30	3
Openness to new ideas / alternative strategies and models.	30	3
Insight into the need for strategic planning, including the need to analyse external and internal environments of services.	27	4
Active participation in discussion.	27	4
Understanding the nature of the problem: insight into the deficiencies of current models of practice.	17	5
Motivation to learn, interest in information and attention given.	14	6

The table illustrates that participants were exploring the problematic issues during the focus group discussions – a high level of critical reflection and identification with problems was displayed, with both being important elements of the process of change (Marzalek-Gaucher & Coffey, 1991; Bailey et al., 1991). Participants illustrated openness to new ideas, an insight into the need for strategic planning, and most significantly, they identified with the need for change in current service delivery models.

Together with the results of the pre-intervention questionnaire, this phase may be described as a pre-change phase or the "unfreezing" phase, as identified by Lewin (1958 in Berger et al., 1980). Participants identified problematic issues regarding service delivery when prompted to do so in the pre-intervention questionnaire, and they explored these issues further in the first online focus group discussion. However, when asked directly in the questionnaire, respondents did not indicate that service delivery models were inadequate. Furthermore, the inconsistent result obtained in the questionnaire that half of the services indicated that they perceived a need for change in service delivery models, was strengthened by the finding regarding the need for change that was evident in the focus group discussions.

"Understanding the nature of the problem" featured second lowest in rating for the focus group, which may explain these inconsistent results and indicate that participants required further exploration and discussion of the issues.

5.1.3 Summary of Consolidated Results and Findings obtained in Phase 1

5.1.3.1 Service Delivery Characteristics

Table 29 provides an overview of the problematic service delivery issues identified during the Pre-intervention Phase, including the nature of the services and the strategies that services are using to cope with some of these issues. Items in the table are not presented in any particular order.

Table 29 Problematic Service Delivery Issues identified and Strategies employed

Nature of Services ↓	**Problematic Service Delivery Issues identified** ↓	**Service Delivery Strategies employed** ↓
Focus on intensive training and re-training of skills (refer discussion on Table 16). Intensive and specialised nature of services (refer discussion on Table 18). Service venues: Mostly home-based and satellite facilities (refer this chapter, Main Venues of Service Delivery)	Inadequate staffing levels (refer discussion on Table 22). Inadequate resources Long waiting lists and inadequate services to clients on waiting lists (refer this chapter, Waiting Lists). Services mostly provided in clinical settings (refer this chapter, Main Venues of Service Delivery). Vast geographical distances covered by services (refer this chapter, Geographical Area Covered by Service).	Use of consultation model (refer Table 20). Use of monitoring model (refer Table 20). Use of direct one-to-one and group models (refer Table 20). Multi-skilling of therapists (refer Table 24). Personnel substitution (refer Table 20).

The table illustrates the focus of services on intensive training and re-training of skills (i.e. the habilitation and remediation models) and the intensive and specialised nature of services (i.e. the sensory integration and neuro-development approaches), making services labour intensive and expensive. When considering the labour intensity of these services further, staffing levels are identified as being inadequate. In addition, resources have been found to be inadequate. Services that have long waiting lists and services to clients on waiting

lists are felt to be inadequate. It is evident that a conflict exists between the intensive and expensive nature of services, and the problematic issues of inadequate staffing and resources. At a Pre-intervention Phase, services are coping with some of these issues by using the consultation, monitoring, direct one-to-one, and group models. Johnson (1996) supports the use of consultation, monitoring and group models as time management strategies. In contrast to the issues identified, the one-to-one model is still used by many services and correlates with the intensive nature of the services. In addition, services utilise multi-skilling of therapists and personnel substitution, as recommended by Salvatori (1997).

The questionnaire also indicated that services are mostly provided in clinical settings – at home bases and satellite facilities of organisations, even though international trends are towards intervention in natural settings and despite vast geographical distances covered by services. When considering these issues, half of the respondents indicated a need for change in current service delivery models on the questionnaire and statements were prevalent regarding the need for change during the focus group discussions.

5.1.3.2 Services' Approaches to Change

Table 30 illustrates the characteristics of services in their general approach to change, as indicated during the Pre-intervention Phase. The table illustrates that, at the Pre-intervention Phase, services have characteristics that provide a sound base for facilitating change. Also indicated are some areas that may inhibit the processes of change. These areas are worth considering as recommendations for practice, which will be discussed in Chapter 6.

Table 30 Characteristics of Services that relate to Approaches to Change

Characteristics that facilitate the Process of Change ↓	Characteristics that facilitate the Process of Change moderately ↓	Characteristics that do not facilitate the Process of Change ↓
Services utilise strategic / business plans and managers view strategic planning as important (refer this chapter: Current Management Practice used).	Managers' moderate identification with the management style of predicting problems (refer Table 25).	Limited time spent on external relations (refer Table 27).
Services have missions and goals (refer this chapter: Current Management Practice used).	Managers' moderate identification with the management task of focusing on external and internal trends (refer Table 25).	Limited time spent on monitoring the environment (refer Table 27).
Services engage in regular assessment of their services (refer this chapter: Current Management Practice used).	Managers' moderate identification with focusing on external changes (refer Table 25).	Managers' comfort level with regard to financial planning (refer Table 26).
Managers' participatory management style (refer Table 25).	Managers' comfort level with regard to the management task of negotiation (refer Table 26).	Managers' limited management training undertaken (refer this chapter: Management Training).
Managers' comfort level with regard to being innovative (refer Table 26).	Managers' comfort level with regard to delegating work (refer Table 26).	Difficulty in implementing change due to limited resources to facilitate change (refer this chapter: Perceptions regarding need for change and perceived difficulty in facilitating change).
Managers' comfort level with regard to facilitating change (refer Table 26).	Managers' comfort level with regard to conflict management (refer Table 26).	Difficulty in implementing change due to limitations in ability for upper management to see need for change (refer this chapter: Perceptions regarding need for change and perceived difficulty in facilitating change).
Managers displaying openness to new ideas (refer Table 28).		
Managers engaging in critical reflection (refer Table 28).		
Managers identifying problems related to service delivery (refer Table 28).	Managers' comfort level with regard to involvement in higher management (refer Table 26).	
Managers identifying the need for change in current service delivery models (refer Table 28).		

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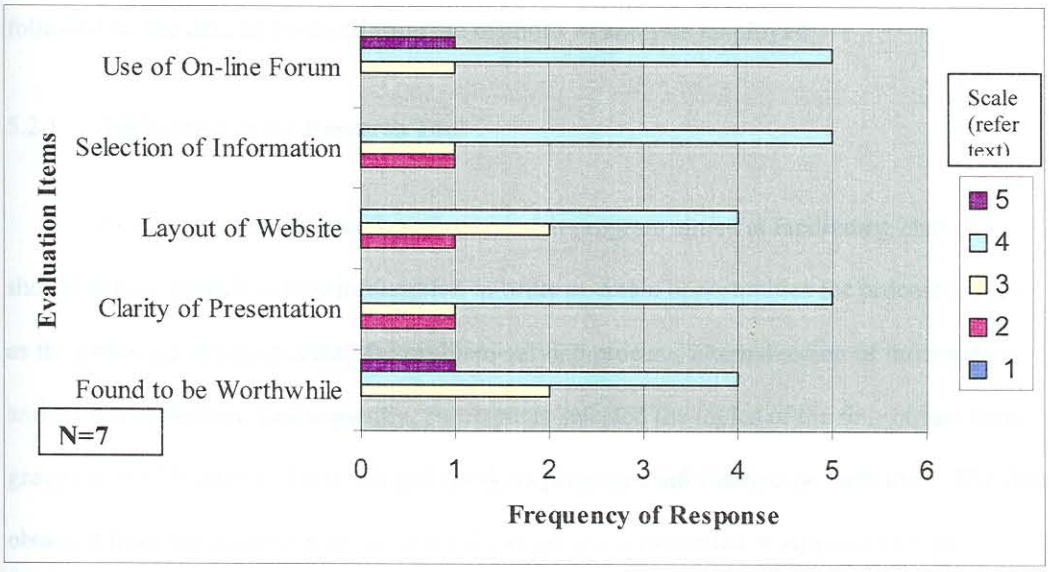
5.1.4 Evaluation of First Focus Group: Short Questionnaire

A short questionnaire was administered after the first online focus group discussion and served as an evaluation in terms of the clarity and appropriateness of information presented in the focus group discussion. Seven short questionnaires were returned after the focus group discussion, after participants were reminded to return them. The low response rate could be contributed to the limited time available to managers, and may indicate that they did not perceive participation in this part of the project as significant related to the other parts.

Participants were asked to rate each item regarding the quality of the information provided and the use of the communication medium. Participants were also asked how applicable the information was to their current settings. Figure 3 indicates the responses with regard to the items on a scale of one to five. "Use of Online Medium" was rated from 1, indicating "Very negative", to 5, indicating "Very positive". "Selection of Information" was rated from "Not appropriate at all" to "Very appropriate". "Layout of website" was rated from "Not clear at all" to "Very clear". "Clarity of Information" was rated from "Not clear at all" to "Very clear", and "Found to be worthwhile" was rated from "Not worthwhile at all" to "Very worthwhile" (refer Appendix I for the short questionnaire used and Appendix M for the raw data for this questionnaire).

In general, the ratings indicate that the majority of participants perceived the presentation of information to be appropriate and clear, the group to be worthwhile, and the experience of the online discussion to be positive. Results were mixed with regard to the application of information to their work settings. Three respondents indicated that it could be applied, two were unsure, another two indicated that it could not be applied, and one respondent indicated that she was looking forward to more discussion on this. A comment was made regarding the different contexts of services and that it was difficult to apply the information to all the different contexts. No further comments were included to indicate which aspects of the discussion were felt to be inapplicable.

Figure 3 Responses to Short Questionnaire: Focus Group 1



Some of the comments indicated that participants felt that they were getting ideas about alternative methods and approaches to service delivery and that involvement in the study was reinforcing their links with other service providers. Some statements read:

"Great to see how other areas are tackling the same issue."

"It was good to hear about the innovative things people are doing, and the fact that we generally share the same problems."

"... It's been very enlightening."

These mixed results seem to indicate that participants in general felt unsure about the application of information in their current settings and that further exploration and discussion of issues and prospective models was warranted.

5.2 PHASE 2: INTERVENTION PHASE

During this phase, information was obtained from online focus groups 2–5, as well as short questionnaires administered after each focus group discussion as an evaluation of the

focus groups. Data will be presented by firstly discussing the application of the research tool, followed by the data as obtained from the methods of analysis employed.

5.2.1 Application of the Research Tool

As discussed in Chapter 3, an intervention program aimed at facilitating change should expose participants to information in order to create opportunities for processes such as the gathering of information, the problem-solving process, internalisation of information, and critical reflection. Consequently, participants selected the topics of the four online focus groups (refer Chapter 4: Table 10) and speakers presented information on each topic. The data obtained from the content analysis of the focus groups is presented in Appendix O. In addition, the findings obtained from the analysis according to pre-set indicators, are presented below.

5.2.1.1 Focus Group Participation

The total number of entries on the website for all four focus groups was 98. Table 31 presents the total number of entries for each focus group and the number of participants.

Table 31 Total Number of Entries for each Focus Group and Number of Participants

	Focus Group 2	Focus Group 3	Focus Group 4	Focus Group 5
Number of entries	36	33	13	16
Number of participants	10	10	6	8

The table indicates that focus group 2 had the most entries. Six metropolitan participants and four country participants participated. Focus group 3 followed second and had five metropolitan participants and five country participants. Focus group 5 was third, with three metropolitan participants and three country participants. Focus group 4 had the least number of entries and five metropolitan participants and three country participants. This was mainly due to the National Occupational Therapy Conference, which occurred in the same

week as the fourth focus group. The general decline in participation may be due to the enthusiasm of participants for the project declining as the project progressed. The timeframe of the project, in combination with the participants' strenuous commitments in terms of time, may also have contributed to this decline. To obtain a better picture of the participation of group members, Table 32 presents the number of statements that provided evidence of the pre-set indicator related to active participation in the discussions (refer to Chapter 4 for a description of the methods of data analysis that were employed). As discussed in Chapter 3, active involvement of participants is required in the discussions in order for an effective problem-solving process to occur.

Table 32 Number of Statements per Group providing Evidence of "Active Participation".

	Focus Group 2	Focus Group 3	Focus Group 4	Focus Group 5
Metropolitan group	29	23	13	12
Country group	25	25	5	17
Total for both groups	54	48	18	29

The table illustrates that most evidence of this indicator was elicited from focus group 2, followed by focus groups 3, 5 and 4. These results correspond with the rankings of the focus groups regarding the number of entries in Table 31.

Discussions occurred mostly during standard office hours but, in comparison with focus group 1, a few more entries relating to focus group 2, did occur outside office hours. This may indicate that participants were exploring the independent nature of online discussions in terms of location (at home or work) and hours (during or outside office hours).

5.2.2 Presentation of Findings

Pre-set indicators were used to determine the managers' approaches to change and whether learning and changes in perception were occurring. The indicators, presented in

Table 33, illustrate the number of statements that provided evidence of each indicator (refer to Chapter 4 for a description of the methods of data analysis). One entry could include one or more statements. The decline noticed in some of the indicators needs to be viewed in conjunction with the patterns of participation, previously illustrated in Table 31 and Table 32.

Table 33 illustrates that, during the focus group discussions, participants were internalising information by providing evidence of preferences in the information presented, of the application of information, and of the assessment of different views. They were also identifying the positive and negative aspects of the model. Examples of these statements are:

"I support any program which aims to engage and empower families ... I also support therapists having a somewhat predetermined caseload where possible as this can help therapists' organisation and stress levels ..."

"The focus on adult learning and parent training rather than on being dependent on the therapist for "hands on" therapy is definitely a strength."

Participants indicated high levels of motivation to learn, as well as interest in information presented and attention given. An example is:

"Thanks for your information. I found it very interesting. It sounds like you are taking on some major challenges. I am interested to know more about ..."

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Table 33 Indicators with corresponding Number of Entries providing Evidence of each of the Indicators per Focus Group

Indicator	Focus Group 2	Focus Group 3	Focus Group 4	Focus Group 5	Total for this Indicator	Rank in relation to other Indicators from most prevalent (1) to least prevalent (6)
Internalisation of information: Sub-indicators:						
Preferences in information presented	11	9	2	10	32	
Application of information	16	7	7	4	34	
Assessment of different views	10	0	1	0	11	1
Identification of positive and negative aspects of model	18	15	7	9	49 Total for this indicator: 126	
Motivation to learn, interest in information, and attention given	20	36	9	10	75	2
Critical reflection regarding the information presented	33	10	6	8	57	3
Openness to new ideas	14	5	1	5	25	4
Commitment to change	3	4	0	9	17	5
Synthesis of old and new views	7	0	0	0	7	6
Decision made to negate current views regarding service delivery models	0	0	0	0	0	7

Rating amongst the highest was "critical reflection" and "openness to new ideas". These findings indicate that participants were engaging with the new information and indicate their general approach of being open to new ideas. Critical reflection forms the basis of change, according to Mezirow (1981), and Jacobs (1999) calls for managers to continually critically analyse situations. Together with "openness to new ideas", participants indicate a sound basis for change in this regard. This supports earlier findings during the first online focus group discussion. Evidencing statements are:

" I like the idea of a pre-determined timetable but also would like to see some flexibility due to the variety of cases we see in the hospital. This is definitely a good way to monitor caseload and allow planning for staff development."

"I like the idea of looking at parent training sessions before commencing therapy..."

5.2.3 Summary of the Findings obtained in Phase 2

In general, these findings indicate an early stage in the process of change where participants are still exploring new information. Evidence suggests that they were engaging with the information (illustrated by their active involvement, their motivation to learn, and the attention given) and that they were involved in an internal process of change (Burkey, 1993; Schurink, 1998), which involves the acquisition and internalisation of information. Findings suggest that participants illustrated high levels of critical reflection and openness to new ideas, which support earlier findings. Participants made fewer references to indicate later stages in the process of change, i.e. indicating a commitment to change, indicating a synthesis of old and new views and a decision to negate current views regarding service delivery models.

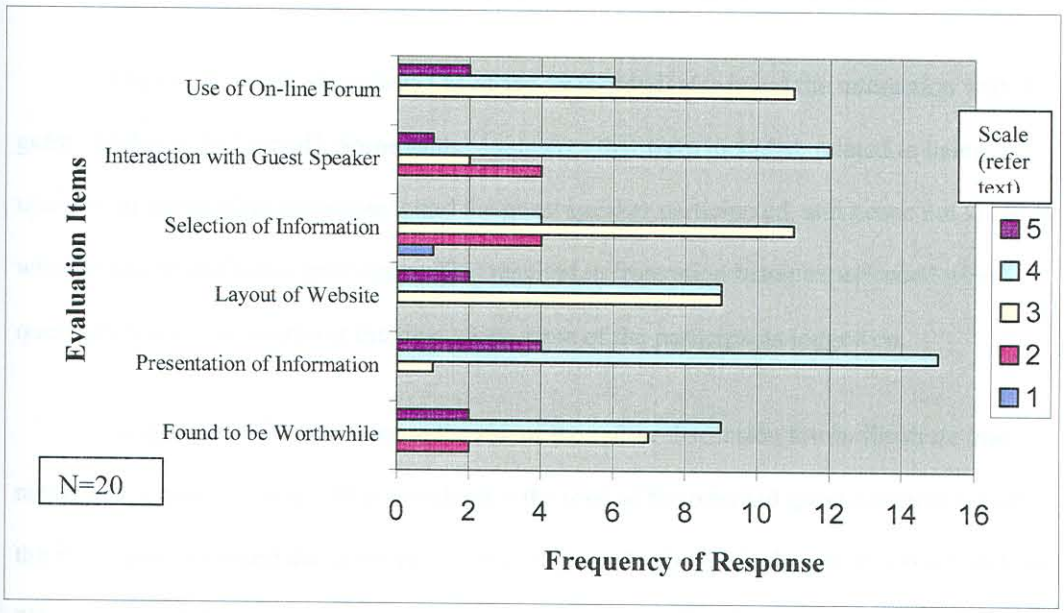
5.2.4 Evaluation of Focus Groups: Short Questionnaires

Short questionnaires were administered after each focus group discussion (refer Appendix J for the short questionnaires utilised). The aim of these questionnaires was to determine the clarity and relevance of the information presented. Even with reminders to return questionnaires, the response rates for the return of the short questionnaires were generally low, with a range of eight returned after the second focus group discussion, five after the third focus group discussion, three after the fourth focus group discussion, and four after the fifth focus group discussion. In total, 20 questionnaires were returned for all four focus groups combined. Given participants' tight time frames, they may not have seen this aspect of the project as a priority.

Figure 4 illustrates the responses of participants, presented as a total across all focus groups. Participants were asked to rate each of the items on a scale from 1 to 5. The first item relates to the degree to which they found the focus groups to be worthwhile, with the ratings ranging from "Not Worthwhile at All" to "Very worthwhile". "Use of Online Medium" was rated from 1, indicating "Very negative", to 5, indicating "Very positive". "Selection of Information" was rated from "Not appropriate at all" to "Very appropriate". "Layout of website" was rated from "Not clear at all" to "Very clear". "Presentation of Information" was rated from "Not clear" to "Very clear" (refer Appendix N for the raw data for this questionnaire).

Most respondents (9 of the 20 respondents for all the focus groups) found participation worthwhile across all focus groups. The focus group that participants found to be most worthwhile was focus group 2 – The Maroondah Approach (4 of 9 responses). Across the four focus groups, participants found the information to be clearly presented (15 of the 20 respondents).

Figure 4 Responses to Short Questionnaire: Focus Groups 2-5



Participants indicated that they found the layout of information to be average (9 out of the 20 respondents) but clearly presented (9 of the 20 respondents). Most participants found the selection of material appropriate (11 of the 20 responses). Focus group 3 (Health Promotion and the Community-based Approach) and focus group 5 (Occupational Therapy in the School System) elicited most scores for the category of "Very Appropriate". Focus group 2 (The Maroondah Approach) was found to be appropriate by most participants.

In order to obtain an overall view of whether participants found the information applicable to their current settings, a relevant question was included in the questionnaire. All respondents to the focus group 5 (Occupational Therapy in the School System) responded that they could apply the model with some modifications. Rating second for application was focus group 3 (Health Promotion and the Community-based Approach), with four of the five respondents indicating that the model was applicable to their settings. Focus group 2 (The Maroondah Approach) had varied results with all participants foreseeing difficulty in applying the model. Focus group 4 (The Hanen Approach) had two of the three respondents

indicating that they would not be able to apply the model currently, but possibly in the future.

The majority of respondents (12 of the 19 respondents) found the interaction with the guest speaker to be "Good". Some of the comments that were included, related to being unaware of when other participants and the guest speaker participated, and hence not knowing when to log on and participate again. This resulted in frustration being experienced when questions were unanswered at the time when some of the participants logged on.

Responses to the question on the use of the online discussion forum illustrate that most participants (11 of the 19 respondents – the total of the returned questionnaires for all the focus groups) found the experience to be "Average" with six finding it "Positive" and two "Very positive". No responses were indicated for "Negative" and "Very negative".

In summary, the short questionnaires indicated that, in general, the material was well presented and appropriate. A few individual differences did occur in participants' perceptions of the appropriateness of some of the material, which indicates the different contexts, previous exposure to other service delivery models and priorities of the various services. Some negative experiences relating to the online discussion medium were highlighted.

5.3 PHASE 3: EVALUATION PHASE

During this phase, the post-intervention questionnaire (consisting of Section B of the pre-intervention questionnaire, refer Appendix C) was re-administered after the conclusion of the focus group discussions. Follow-up interviews were conducted two months after the focus group discussions ended. The aim of this phase was to analyse perceptions regarding short- and long-term changes in practice. The post-intervention questionnaire focused on identifying changes in perceptions, while the interviews focused on changes in practice. Fourteen managers participated in this phase. The results and findings that emerged from this phase are presented as follows: Firstly, the application of the research tools, followed by a discussion on

the consolidated results obtained from these tools, which include:

- A comparison of participants' perceptions relating to the strategies employed to deliver services before and after the change-orientated program.
- A description of services' approaches to change in service delivery.
- A description of recent changes made to service delivery models and / or service delivery models considered for change.
- Participants' perceptions regarding best practice principles.

5.3.1 Application of Research Tools

5.3.1.1 The Post-intervention Questionnaire

The post-intervention questionnaire was analysed by means of descriptive statistics and compared with the results obtained in the pre-intervention questionnaire. When examining the results obtained in the questionnaire, the small number of participants, and the fact that a change in one response would result in a 7% variation, needs to be taken into consideration. For this reason, both the actual response numbers and the percentages are provided. Data analysis was limited to descriptive methods since the small number of participants made more sophisticated analyses inappropriate.

The results of the post-intervention questionnaire also need to be viewed within the context of changes that have occurred and are occurring in practice, independently of the change-orientated program (i.e. the Intervention Phase) itself. Furthermore, in order to obtain a holistic view of the changes in perceptions that are occurring, the results need to be viewed together with the qualitative data obtained from the interviews.

5.3.1.2 Follow-up Interviews

Fourteen follow-up interviews were conducted. Analysis of the interviews consisted

of two strategies of analysis according to pre-set indicators (refer Chapter 4, Table 11). The strategies of data analysis that were utilised, focused on identifying longer-term changes in practice and approaches to change. During the interviews, participants were also asked to verbalise their perceptions regarding the coverage of the project and their involvement in the project.

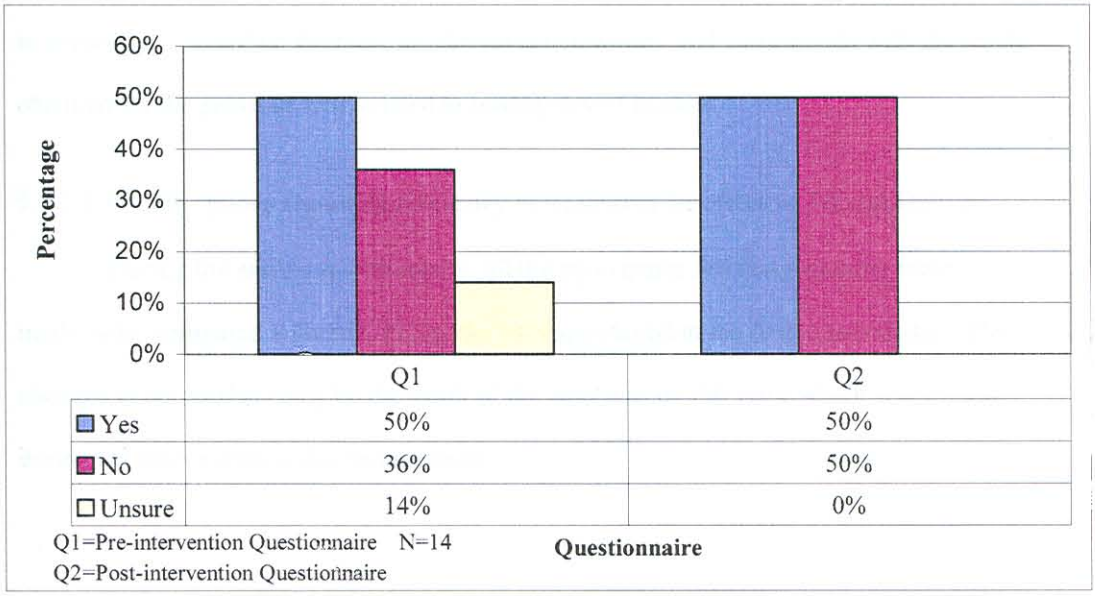
5.3.2 Presentation of Consolidated Results and Findings

5.3.2.1 Participants' Perceptions of Strategies employed to deliver Services

5.3.2.1.1 Perceptions regarding Adequacy of Current Service Delivery Models employed

The responses of the second questionnaire indicate that two more participants felt that current service delivery models were inadequate (refer Figure 5). A change can be seen in the perceptions of those who felt unsure of whether service delivery models were adequate during the first questionnaire (with two participants fewer indicating that they are unsure).

Figure 5 Adequacy of current Service Delivery Models employed



The half-half split in perceptions is noteworthy and suggests that services are divided

in their perceptions. This division may reflect the different needs in the variety of service delivery contexts. It may also indicate the impact of changes that have already occurred in practice.

5.3.2.1.2 Perceptions of the Need for Change in terms of current Service Delivery

Changes in perceptions indicated by the second questionnaire, show that one participant was less unsure about the need for change and another felt that change was not required (refer Table 34). This result seems to contradict the previous result regarding adequacy in current service delivery, but may indicate ambiguity relating to the term "change". Some participants have indicated that they do not see a need for change, but indicated qualitatively that they were considering changes to the way they are delivering services. The term "change" may indicate to some a major change in direction, while others may have seen it as including the introduction of certain strategies within their current service delivery models. Results may also have been influenced by changes that had already been implemented in practice since the administration of the first questionnaire. The half-half split in perceptions regarding the need for change is noteworthy and corresponds with the results obtained for the previous item related to inadequacy of models.

5.3.2.1.3 Perceptions regarding Adequacy of Resources for effective Service Delivery

During the second questionnaire, all the participants felt that resources were inadequate, compared with 86% (12 of the 14 respondents) in the first questionnaire. The changes in perceptions may be the result of the emphasis on this issue which was evident during the discussions in the focus groups.

Table 34 Perceptions of the Need for Change in terms of current Service Delivery

Question	Q 1 Yes	Q2 Yes	Q1 No	Q2 No	Q1 Unsure	Q2 Unsure
Perceived need for change in service delivery model	7 (50%)	7 (50%)	6 (43%)	7 (50%)	1 (7%)	0 (0%)
N=14						

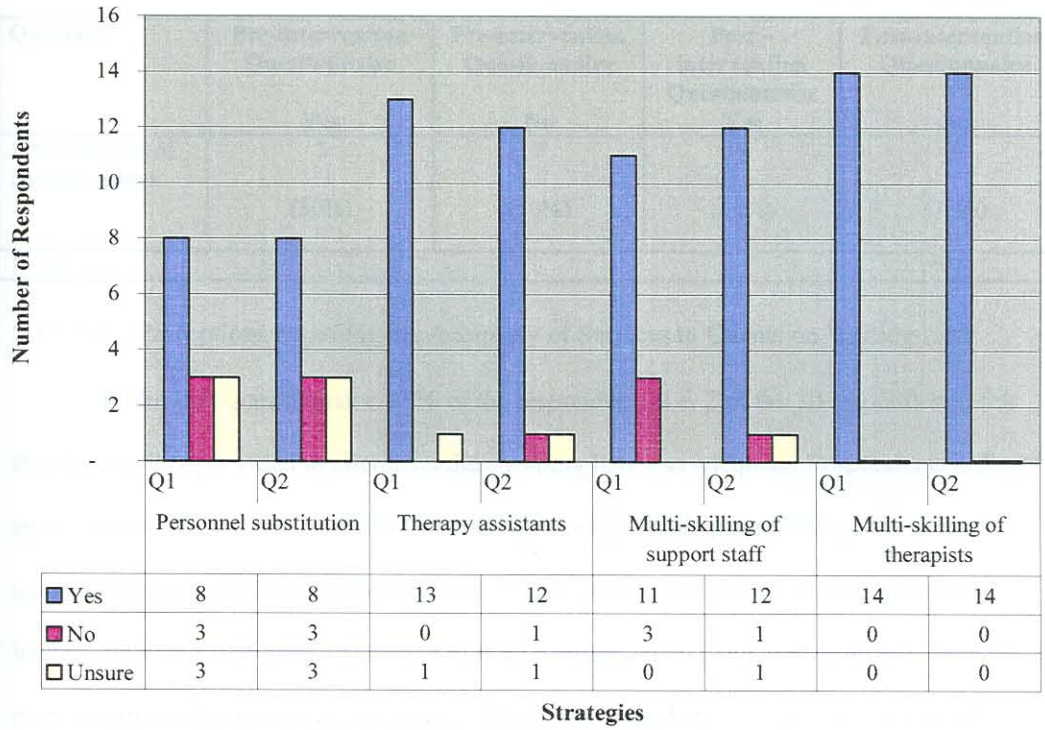
Q1 = Pre-intervention Questionnaire
Q2 = Post-intervention Questionnaire

5.3.2.1.4 Consideration of the Use of Staffing Strategies

Figure 6 indicates the responses to this question.

Participants' perceptions were relatively similar in terms of their responses in the pre-intervention questionnaire and the post-intervention questionnaire. A variation was noted in the perceptions regarding the use of multi-skilling of support staff – the number of participants who would have considered using it during the post-intervention questionnaire, had increased by one participant; a decrease had occurred in the number who would not have considered using it (two participants fewer); and there had been an increase of one participant who felt unsure about this strategy. In addition, one participant fewer indicated in the post-intervention questionnaire that they would consider the use of therapy assistants. These results may be attributed to the discussions of focus group 3 (NHS: Occupational Therapy Services for Children) and 5 (Occupational Therapy in the School System), which included references to this topic. The changes that had already been made in practice since the administration of the first questionnaire, may also have influenced these results.

Figure 6 Considerations related to the use of Staffing Strategies



5.3.2.1.5 Effectiveness of current Venues and Preference of Use of Venues

Regarding the question of whether participants felt that their current venues were effective for service delivery, an increase was observed in the number of participants who felt that they were effective and a decrease was observed in those who felt that they were ineffective (refer Table 35). Two services indicated qualitatively that they had undergone changes with regard to their venues since the first questionnaire had been administered. These practical changes resulted in fewer perceptions regarding the inadequacy of venues.

Table 35 Perceptions regarding the Effectiveness of current Venues

Question	Pre-intervention Questionnaire Yes	Pre-intervention Questionnaire No	Post – intervention Questionnaire Yes	Post-intervention Questionnaire No
Effectiveness of current venues	7 (50%)	7 (50%)	9 (64%)	5 (36%)
N=14				

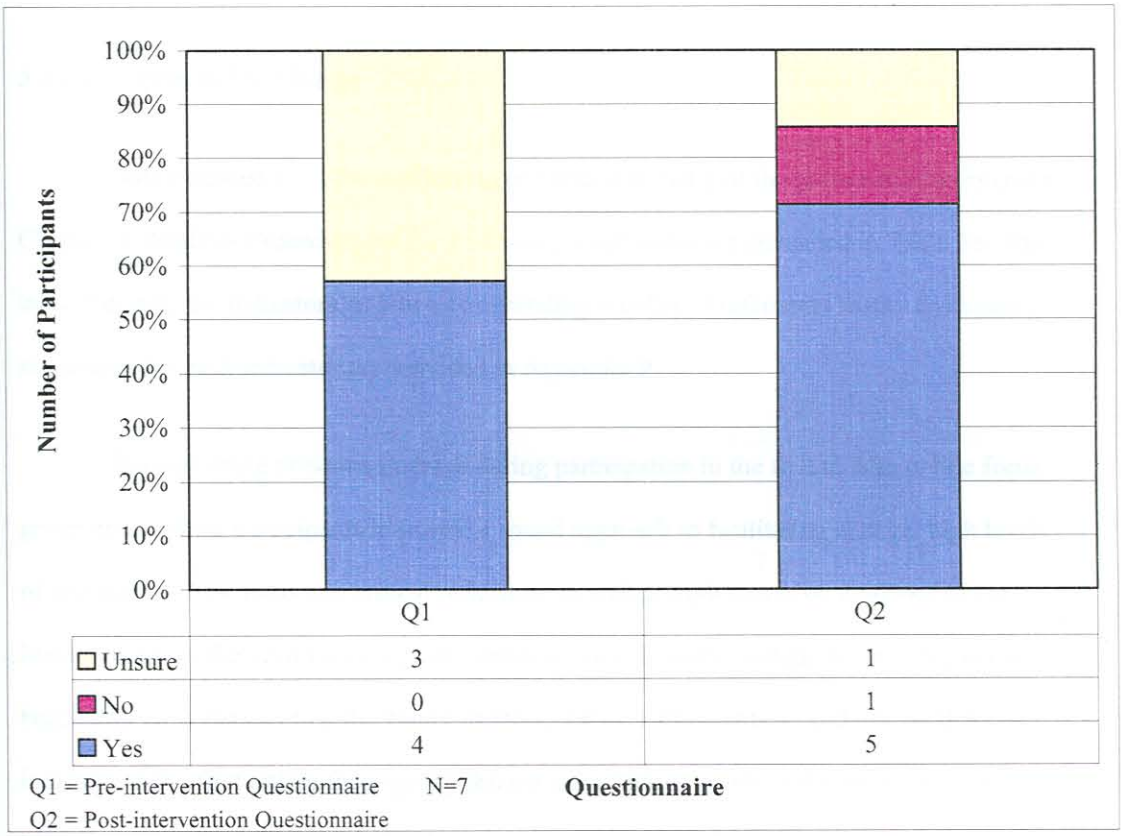
5.3.2.1.6 Perceptions regarding the Adequacy of Services to Clients on Waiting Lists

In the first questionnaire, 20% of the respondents (i.e. 2 of the 10 respondents) felt that the services provided to clients on their waiting lists was adequate. Respondents indicated an increase in the number who felt that such services were adequate (36% on the second questionnaire, i.e. 5 of the 14 respondents). Eighty percent felt that such services were inadequate in the first questionnaire (8 of the 10 respondents) compared with 64% (9 of the 14 respondents) in the second questionnaire. These variations in perceptions can be contributed to the strategies that some services had implemented since the administration of the first questionnaire. Three respondents indicated in the comment section that they had implemented strategies and hade reduced their waiting lists.

5.3.2.1.7 Difficulty in facilitating Change

Fifty percent of the participants (7 participants) responded to this sub-question (refer Figure 7 for responses). One more participant perceived that he / she would have difficulty in facilitating change. Noteworthy is that fewer participants felt unsure regarding their perceptions. One more indicated that he / she did not perceive difficulty in facilitating change. Again, this result may indicate some changes that had already occurred in practice.

Figure 7 Difficulty in facilitating Change



In summary, the post-intervention questionnaire in general indicated a decrease in the number of participants who felt unsure about certain questions in the pre-intervention questionnaire. It appeared that some participants had benefited from the program by formulating more distinct opinions. This may have been due to the fact that participants had been considering the factors involved in the process of change more frequently than before, as a result of the discussions. Other changes of significance were an increase in the number of respondents who felt that resources were inadequate and an increase in those who perceived current service delivery models to be inadequate. Other changes not directly related to the change-orientated program, had occurred in practice since the administration of the pre-intervention questionnaire. These changes impacted on the results obtained and included: perceptions relating to adequacy of venues, adequacy of services to clients on waiting lists,

and the need for change.

5.3.2.2 Approach to Change

Data obtained from the application of Method B, Set 1 of the pre-set indicators (refer Chapter 4: Analysis Procedures of the Follow-up Interviews) are presented in Table 36. The table indicates the indicators and the corresponding number of references made. Evidencing statements for each indicator are provided in Appendix P.

Strengthening previous findings during participation in the first to fifth online focus group discussions, participants indicated a sound approach to facilitating change: high levels of openness to new ideas and critical reflection, as well as high scores on evidence of the identification of the need for change in current service delivery models. Noteworthy is the high score on understanding the nature of the problem. Participants scored low on this indicator in the first online focus group discussion, which suggests that participants had benefited from the focus groups by discussing issues and developing an increased understanding of the nature of the service delivery problems. This is an important step in the problem-solving process, which in turn, forms part of the process of change (Marzalek-Gaucher & Coffey, 1991). Also noteworthy is the high score on a commitment to change. Vestal (1995) includes this step in the problem-solving process, which indicates a strong indication of commitment to pursuing a process of change.

Of interest is that "evidence of a synthesis of old and new views" scored higher than "evidence of a decision to negate current views and moving onto a different model". These steps form part of the final stages of the process of change, as discussed by Gravett and Peterson (2000), and indicate different ways in which services adapt to changes. This finding suggests that participants were more open to synthesising old and new views than abandoning old approaches completely.

Table 36 Approach to Change and longer-term Indicators of Change

The Pre-set Indicators	Number of References providing Evidence	Ranking of Indicators in order of most Prevalent to least Prevalent
Evidence of openness to new ideas / alternative strategies and models.	35	1
Evidence of critical reflection regarding models.	33	2
Evidence of identification of the need for change in current service delivery models.	29	3
Evidence of understanding the nature of the problem: insight into the deficiencies of current models of practice.	21	4
Evidence of commitment to change. This indicates a more permanent statement than in "Evidence of identification of need for change". It indicates a definite decision made or preliminary plans made to implement changes.	19	5
Evidence of insight into the need for strategic planning, including the need to analyse external and internal environments of services.	16	6
Evidence of internalisation of information: Indicate preferences in terms of information. Indicate the application of information in own and / or other settings. Indicate the assessment of different views./ evidence of having thought about the information.	 2 8 5 Total: 15	7
Actions taken / effort regarding implementation of changes in terms of: Workforce development / changes.	15	7
Actions taken / effort regarding implementation of changes in terms of: Organisational and / or procedural development / changes.	13	8
Actions taken / effort regarding implementation of changes in terms of: Resource allocation or applied for funding to implement changes: financial / equipment / work space.	8	9
Evidence of a synthesis of old and new views, that is the use of certain new concepts of a different model combined with current practice.	7	10
Actions taken / effort regarding implementation of changes in terms of: Development of partnerships and networks.	4	11
Evidence of a decision made to negate current views regarding current service delivery models and moving onto a different model.	1	12

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In general, these findings suggest that one of the major results of the change-orientated program was the opportunities it created for critical reflection on practice. Secondly, it illustrated the progress of participants from the earlier stages in the process of change to the later phases, indicating identification with the need for change, commitment to change, and changes implemented in practice.

5.3.2.3 Recent Changes made to Service Delivery Models and / or considered for Change

Findings obtained from using the pre-set indicators (refer Table 36), suggest that services are implementing changes related to workforce development and organisational / procedural developments. Less evidence was obtained relating to resource allocation that corresponds with previous findings indicating resources as a difficulty in implementing change in services. Scoring lowest were references made to the development of partnerships and networks in implementing change. This finding strengthens the previous findings suggesting a limitation in services related to the building of external relationships.

Table 37 illustrates the data obtained from Method B, Set 2 of the pre-set indicators (refer Chapter 4: Analysis Procedures of the Follow-up Interviews). It indicates recent changes made to service delivery models or consideration given to changes to these models (in order of most prevalent to least prevalent). The number of statements provides a weight to the evidence of each service delivery model and refers to the number of services that have indicated these models.

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Table 37 Recent Changes in Service Delivery Models and / or Service Delivery Models considered for Change

Service Delivery Model	Number of Statements
Early intervention, prevention and client education	10
Health promotion	9
Client- / family-centred service delivery	7
The use of support staff, multi-skilling, and personnel substitution	7
Trans-disciplinary teamwork	6
Interagency collaboration	5
Case management	4
Direct, groups	4
Collaborative consultation	4
The community-based approach	4
Intervention in functional environments	4
Multi-disciplinary	3
Inter-disciplinary	3
Home- / community-based service delivery	2
Direct, one- to- one service delivery	2
Centre-based service delivery	1
N = 14	

The table illustrates that most services are considering or have implemented changes to incorporate principles of the early intervention, prevention, and client-education models. In the pre-intervention questionnaire, 10 of the 14 services indicated that they were utilising the prevention model (refer Table 16). It is unclear whether services that indicated these models in the pre-intervention questionnaire also indicated changes to these models in the follow-up interviews, or whether the result includes services that implemented new directions towards this model. Again, it seems that the term "change" was interpreted differently by participants, with some respondents using examples of major changes, and others discussing minor

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modifications to current ways of service delivery. In addition, the different categories utilised in the pre-intervention questionnaire and the interviews, make direct correlation difficult. The result seems to indicate that services are strengthening and refining their services in the application of this model and it confirms previous results regarding the use of this model. Similarly, services are also making changes to the application of the health-promotion model (9 of the 14 services utilised the model in the pre-intervention questionnaire – refer Table 16) and the family-centred model (11 of the 14 services indicated its use in the pre-intervention questionnaire – refer Table 18). The format of the questions also has to be considered – no prompts where given to participants during the follow-up interviews, while the participants had a selection of options to choose from during the pre-intervention questionnaire. Half of the services indicated that they were considering or implementing changes regarding the use of support staff, multi-skilling, and personnel substitution. This correlates with the high number of services indicating that they would consider these staffing strategies (refer Figure 6).

References were also made, to a lesser extent, to: interagency collaboration, case management, groups, consultation, and community-based approaches and intervention in functional environments. Three or fewer references were made to multi-disciplinary and inter-disciplinary models, home- versus community-based models, the direct one-to-one model, and centre-based service delivery. Of interest is that four services initially indicated that they were utilising the case management approach (refer Table 20) and that four were considering or implementing changes to the case management approach after the change-orientated program. Again, it is unknown whether the four that were initially using the model were refining their models, or whether it was four new services that were making changes towards this model. The result may suggest a shift towards the increased use of the model. This also applies to the community-based approach (with six services using it before the change-orientated program) and the trans-disciplinary model (with six services were using it before

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the change-orientated program).

The use of direct, one-to-one models and groups remain fairly stable (featuring amongst the most prominent service delivery models used before the change-orientated program – refer Table 20) and few changes seem to have been made to, or are planned for, these models. The finding suggests that while one-to-one models are still considered due to the effectiveness of individualised programs, as supported by Shonkoff and Meisels (2000), other models are now considered for use in combination with this model. This utilisation of a combination of models is recommended by Dunn (2000) and the AOTA (1989) and is supported in the results of Springfield, Rodger and Maas (1993) during their survey of paediatric occupational therapists in Queensland. These researchers found that the majority of their respondents were utilising more than one model. In addition to these findings, general statements were made regarding the delivery of Occupational Therapy services in South Australia. These have been compiled and are presented in Appendix R.

5.3.2.4 Perceptions regarding Best Practice Principles

Participants were asked what their perceptions were regarding best practice principles in the field of early intervention. When considering these findings, it is important to recognise that this is an early attempt at developing a framework for early intervention practices in South Australia. No guidelines were given to participants in terms of selecting these principles. Participants spoke passionately about what they believed these principles were. It is worth noting that grey areas and overlap exist within the terminology. This section of the study warrants further, more in-depth investigation to obtain a comprehensive framework for practice.

The data in Table 38 indicates the rating of the most frequent references to certain service delivery models. Appendix Q provides the relevant statements in support of each

model. In addition to the above perceptions of best practice, some relevant statements made by participants are included in Appendix S.

Table 38 Perceptions regarding Best Practice Principles

Service Delivery Model	Number of References	Rating according to Prevalence
Early intervention, prevention and client education	7	1
Client- / family-centred services	5	2
Use of support staff, multi-skilling, and personnel substitution	4	3
One-to-one, direct service delivery	3	4
Health promotion	3	4
Intervention in functional environments	3	4
The community-based approach	3	4
Groups	2	5
Collaborative consultation	2	5
Centre-based	1	6
Trans-disciplinary	1	6
Interagency collaboration	1	6
Case management	0	7
Multi-disciplinary	0	7
Inter-disciplinary	0	7
Tele-Rehab / Health	0	7

Noteworthy is that the ratings pertaining to early intervention, prevention, and client education, correspond with recent changes made to service delivery (refer Table 37). Also worth noting are the other models that the participants mentioned, given that participants had no guidelines or prompts. The weight attached to the number of references is difficult to interpret, given that participants had no guidelines. Further investigation of these principles is

warranted.

5.3.3 Summary of Consolidated Results and Findings

Findings indicate that, after participation in the change-orientated program, participants are less unsure about certain problematic aspects of service delivery than before. More participants feel that current service delivery models and resources are inadequate. More indicated that they perceive difficulties in facilitating change. These results may indicate that participants have benefited from the change-orientated program by forming more distinct opinions. Furthermore, during the focus group discussions, participants indicated an increased understanding of the nature of the problems and showed more distinct commitments to change.

In conjunction with the findings obtained in the Pre-intervention and Intervention Phases, the characteristics of services that relate to services' general approach to change, were compiled. Table 39 provides these characteristics. The table illustrates that services have characteristics that provide a sound basis for facilitating change. Also indicated are some areas that may inhibit the processes of change. These areas are worth considering as recommendations for practice, and are discussed in Chapter 6.

This section also indicates that most services are strengthening and refining their early intervention, prevention and client-education models, as well as their health promotion and family-centred models. Services are considering staffing strategies. Findings suggest shifts in perceptions regarding the applications of the case management, community-based and trans-disciplinary models. The use of groups and one-to-one service delivery remain prominent.

Table 39 Characteristics of services that relate to the General Approach to Change

Characteristics that facilitate the Process of Change	Characteristics thatfacilitate the Process of Change moderately	Characteristics that do not facilitate the Process of Change
Services utilise strategic / business plans and managers view strategic planning as important (refer this chapter: Pre-intervention Phase, Current Management Practice Used).	Managers' moderate identification with the management style of predicting problems (refer Table 25).	Limited time spent on external relations (refer Table 27).
Services have missions and goals (refer this chapter: Pre-intervention Phase, Current Management Practice Used).	Managers' moderate identification with the management task of focusing on external and internal trends and changes (refer Table 25).	Limited time spent on monitoring the environment (refer Table 27).
Services engage in regular assessment of their services (refer this chapter: Pre-intervention Phase, Current Management Practice Used).	Managers' comfort levels in the management task of negotiating (refer Table 26).	Managers' comfort levels in financial planning (refer Table 26).
Managers' participatory management styles (refer Table 25).	Managers' comfort levels in delegating work (refer Table 26).	Managers' limited management training undertaken (refer this chapter: Pre-intervention Phase, Management Training).
Managers' comfort levels in being innovative (refer Table 26).	Managers' comfort levels with regard to conflict management (refer Table 26).	Difficulty in implementing change due to limited resources to facilitate change (refer this chapter: Pre-intervention Phase, Perceptions regarding Need for Change and perceived Difficulty in facilitating Change).
Managers' comfort levels in facilitating change (refer Table 26).	Managers' comfort levels in involvement in higher management (refer Table 26).	Difficulty in implementing change due to ability of upper management to see need for change (refer this chapter: Pre-intervention Phase, Perceptions regarding Need for Change and perceived Difficulty in facilitating Change).
Managers displaying openness to new ideas (refer Table 28, Table 36).		
Managers engaging in critical reflection (refer Table 28, Table 33, Table 36).		
Managers identifying and understanding problems related to service delivery (refer Table 28 and Table 36).		
Managers identifying the need for change in current service delivery models (refer Table 28, Table 36).		
Managers illustrating motivation to learn and internalisation of information (refer Table 33).		
Managers illustrating a commitment to change (refer Table 36).		

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In overview, this study illustrates the perceptions of participants regarding the processes of change that are currently occurring in the participating services – both as result of the impetus of the change-orientated program, and independently of this program. The process of change in services are illustrated from the early phases of problem identification to the later phases indicating participants' commitment to change and the implementation of changes in practice. Lastly, findings related to best practice principles are identified as a first attempt at exploring these principles.

5.3.4 Participants' Evaluation of the Project

As part of the interviews, participants were asked to verbalise their perceptions regarding the coverage of the project, as well as their involvement in the project.

5.3.4.1 Coverage of Project

Participants were asked whether there were any significant issues or strategies regarding service delivery in paediatrics that had not been covered by this project and which they would like to talk about or emphasise. All the participants indicated that they supported the project in terms of its coverage of the phenomenon, for example:

"From what I saw earlier on in the discussions, I think you have been able to pick up on a broad range of the issues across the state..."

Participants indicated the value of the information which had been provided in the online focus group discussions:

"...have kept all the information...will be a good reference when we are thinking about changes in the future."

Some participants included additional statements that are worth noting when

considering this study's results:

- One emphasised that, for some organisations, it is difficult to isolate occupational therapy from the other disciplines when one is investigating early intervention service delivery. This participant emphasised the holistic nature of service delivery.
- Another stated the value of debating early intervention literature and whether occupational therapists should prioritise intervention to younger children in favour of children of school-going age. This participant indicated that occupational therapists have different views on this particular issue.
- The limited time available to managers, in terms of participating in projects such as this one, was mentioned by another participant.

5.3.4.2 Participants' Involvement in the Project

Participants were asked to talk about their feelings regarding their involvement in the online discussion groups.

Three main aspects emerged from the data (refer Table 40):

- benefits of the online discussion medium;
- disadvantages of the online discussion medium;
- identification with the material presented.

Table 40 Participants' Experiences in the Use of the Online Discussion Groups

Category	Example of Statement
Benefits of the online discussion medium	"I think it is a great idea … it is efficient in terms of not having to travel somewhere." "I thought it was easier to get people to give their input because it is very difficult to get paediatric occupational therapists to commit their time."
Disadvantages of online discussion medium	"… time was really limited …"
Identification with material presented	"But I can see a couple of points in there that can be taken on board …"

Table 40 illustrates the statements made regarding the benefits of using the online discussion forum. All participants commented on the usefulness of the online discussions. Benefits of the online discussions identified by the participants were: to share information and stimulate reflection (supported in the literature by McConnel, 1994); the convenience and practicality in relation to travel and time commitments (supported by McConnel, Lewis & Kaas, 1998; Ryan, Carlton & Ali, 1999); as well as the value of facilitating relationships between services (supported by Ryan, Carlton & Ali, 1999). These benefits added to the initial rationale for utilising online discussion groups (refer Chapter 2, Online Computer Conferencing). The participants in regional areas especially seemed to value the communication with other occupational therapists. Further comments included the value of being able to re-visit contributions online and being able to take one's time in responding to it. Several mentioned that it was a new and very worthwhile experience for them.

Participants also identified disadvantages of using this medium. The disadvantages included technical difficulties and the sharing of computers, time limitations of managers, as well as the limitations of online discussion versus face-to-face discussion (with regard to the limited in-depth discussions). The frustration experienced due to the time lapse between messages was mentioned by participants in the interviews as well as in the short questionnaires administered after the focus group discussions. No relevant literature

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references were found to compare these disadvantages with. It is therefore anticipated that this study's findings regarding the use of online focus groups has furthered research knowledge in this regard.

In addition, five of the interviews contained statements from participants related to identification with information presented and that they are considering some of the strategies mentioned. This finding needs to be viewed within the different contexts of services and the comment made in a short questionnaire regarding the difficulty of applying the information to all the different contexts of the services.

5.4 SUMMARY OF CHAPTER

This chapter presents the results and findings of the Pre-intervention, Intervention, and Evaluation Phases of the project. A consolidation and summary of the results and findings are provided. Chapter 6 focuses on a critical discussion and evaluation of this project with recommendations and concluding remarks.

6 CONCLUSION, CRITICAL EVALUATION AND RECOMMENDATIONS

Chapter 5 provided a detailed layout of the results and findings of the study. The chapter presented a discussion of the following main comparative results:

- Characteristics of services rendered before the intervention phase: Problematic issues identified in services rendered before the intervention phase include: inadequate staffing levels; the labour intensity and specialised nature of the services; inadequate resources to deliver services; long waiting lists; and inadequate services to clients on waiting lists. Services are mostly provided by means of the consultation, monitoring and direct models (one-to-one and groups) and are delivered mostly in clinical settings. Most of the service delivery models used can be correlated with international trends, except for the limited use of the community-based model. In addition, some participants identified collaboration with the school system as being inadequate, thereby adding to the list of problematic issues in service delivery.
- Processes of change that occurred in managers' perceptions after the intervention phase: Results suggest that some participants benefited from the intervention phase by forming more distinct opinions. An increase has been noted in perceptions regarding: inadequate resources; adequacy of service delivery models; understanding the nature of the problems; and distinct commitments to change. In addition, a decrease has been noted in the number of participants who feel unsure about certain aspects of service delivery.
- The service delivery models that services were using before and after the intervention phase respectively: Findings seem to suggest that services are strengthening and refining their services in the application of the early intervention, prevention and client-education models, as well as in health promotion and the family-centred models. Staffing strategies are considered or used by many services. The use of direct, one-to-one and group models remains prominent and few changes to these models are being considered. Findings may

suggest shifts in the perceptions regarding the use of the case management, community-based and trans-disciplinary models. Further findings suggest that services are implementing changes related to workforce development and organisational / procedural development. Resource allocation and development of partnerships are less evident changes. Perceptions regarding best practice principles have also been identified and have provided an early attempt at exploring these principles. Rating highest amongst these principles are the early intervention, prevention, client-education and client / family-centred models, as well as the use of staffing strategies.

Throughout all the phases of the project, the processes of change in services have been illustrated from the initial phases of problem identification to the later phases of indicating participants' commitment to change and the implementation of changes in practice. Noteworthy is the high evidence of participants' critical reflection on practice. In addition, the characteristics of services' approaches in the process of change management have been identified. The characteristics suggest that services have a sound base for facilitating change, with characteristics related to management style, the management tools utilised (for example strategic planning), and managers' approaches to change. Characteristics that facilitate the process of change moderately have been identified and relate to management style and managers' comfort levels with regard to certain management tasks. Noteworthy is the identification of characteristics that may inhibit processes of change: the limited focus of services on external factors influencing service delivery; limited management training undertaken and the difficulties in implementing change due to limited resources; and the ability for upper management to see the need for change.

Chapter 6 will critically evaluate the results and findings of the study, and will include a discussion of the research design utilised. Recommendations for future research and for practice will also be made in this chapter.

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6.1 EVALUATION OF THE RESEARCH DESIGN

The results and findings of this study need to be viewed within the context of a number of factors. These include: the difficulty in defining the concept of early intervention and consequently the impact of these variances on the study; the variation amongst the targeted population group under investigation; the design and methodology utilised; the timeframe of the project; and the difficulty in capturing and measuring processes of change. In addition, the application of online focus groups in this project requires some consideration.

6.1.1 The Concept of Early Intervention

The dilemma surrounding the definition of "early intervention", as discussed in Chapter 2, was demonstrated during this project in that variations exist amongst services regarding this concept. Some services prioritise different age groups under this term. In addition, the variety of disciplines involved in service delivery and the consequent focus of service delivery varied amongst services. The developing nature of this field also provided difficulties, with some services prioritising the early childhood period and others providing a combination of early intervention as well as other services, for example services to children of school- going age. This difficulty was addressed by using a combination of data collection methods and bearing the individual context of each organisation in mind. The use of the questionnaires, combined with the discussions and interviews, allowed for these differences to surface in order to be considered during the data analysis and interpretation phases.

Although definitions of terminologies were provided, terminology such as that pertaining to the different team approaches, and the case management and consultation models in particular, proved to be interpreted and applied by participants in different ways. The different interpretations need to be considered when interpreting this study's results and may warrant further investigation in order to obtain a more accurate and in-depth

understanding of these models and their interpretations in practice.

6.1.2 The Targeted Population Group under Investigation

The occupational therapy managers selected to participate provided some variation amongst services and the information obtained. This is due to the varied natures of organisational structures, the different contexts of services across the state, as well as in the variety of the application of early intervention services. Some participants found it difficult to isolate occupational therapy managers when studying the phenomenon of early intervention, due to the multi-disciplinary nature of the field. A recommendation for future research would be to include other disciplines in a study related to early intervention service delivery in order to obtain a multi-disciplinary perspective. For the purposes of this study, the occupational therapy perspective proved to be valuable.

In addition, some managers were not directly involved in the field of early intervention and had limited clinical experience in this regard. Others served as both managers and clinical therapists, with another temporarily attending to the management role, while being a clinical therapist. Due to the limited sizes of some organisations, one therapist would attend to both roles while having no staff to oversee. To accommodate for limited clinical experience, some managers participated together with a clinical therapist in cases where this situation could be foreseen. However, this was not possible in all the cases. This resulted in some variation in the information obtained, especially regarding management-specific information. These variations and context-specific situations were taken into account when interpreting the data.

Findings from the short questionnaires and the question related to coverage of the project in the follow-up interviews, highlighted the varying contexts of the services across the state. These variances impacted on the study. As indicated by the services, all the

information provided to services may not have been appropriate, though a high number of participants still indicated that the focus groups were worthwhile. These variances also made the pre- and post-test design difficult to execute and contributed to the variations in the results obtained.

Due to the nature of the positions held by the participants, time to participate was a significant factor that had to be kept in mind in the planning of the project. Online focus groups proved to be appropriate to allow for participation in places and at times that were convenient for the participants. Limitations were however observed in participation due participants' restrictions in terms of time.

The number of participants and its influence on the depth of statistical analysis warrants discussion. Due to the small number of participants (14), statistical analysis was restricted to descriptive statistics. Although this was a limitation in terms of the research, it was not the only focus of the study and the data obtained from the questionnaire was supplemented by the data obtained from the other tools.

6.1.3 Design, Methodology and Timeframe of the Project

The use of aspects of the participatory action research approach, the pre-post test design, as well as the methodology employed at each stage of the project and the timeframe of the design proved to be appropriate for a variety of reasons. Firstly, it facilitated active discussion and critical reflection from participants, which is the basis for facilitating change in organisations. It also allowed for reflection and discussion over a period of six months and by means of different mediums. The project was effective in corresponding with the aim of the participatory action research design, as stated by DePoy and Gitlin (1998), in order to generate knowledge to inform action in practice.

Secondly, the design proved to be appropriate in providing factual as well as

rich descriptive information. The factual nature of the data obtained from the first questionnaire provided a valuable, measurable and concrete starting point for discussions. The data obtained from the second questionnaire provided concrete evidence to compare with the results of the first questionnaire, although it was limited with regard to the statistical analyses (as discussed previously). The focus groups provided complementary descriptive and contextual data. In addition, the timeframe of the design allowed for the follow-up interviews to be individually tailored according to a pre-set structure in order to provide more opportunity for in-depth and context-specific data to be obtained.

A limitation was the different categories utilised during the pre- and post-tests (except for the questionnaire, which remained the same) and the pre-set indicators utilised during the first focus group's discussions, the discussions of focus groups 2–5, and the interviews. These inconsistencies made direct comparisons between the pre- and post-intervention findings difficult.

The unprescriptive nature of the participatory research design allowed for data collection methods to be used in combination (DePoy & Gitlin, 1998; Hart & Bond, 1995). Several authors, including DePoy and Gitlin (1998), as well as Kohn, LeBlanc and Mortola (1994), support the use of a combination of data collection methods to study a phenomenon. This was a strong point in the design of the project since it allowed for data collection methods to compliment each other. It also allowed for contextual information to be gathered and strengthened the validity and reliability of the results and findings obtained.

In addition, the approach adopted allowed for flexibility in the application of the design, as well as the control and structure provided by the researcher. In this instance, participants were actively involved in discussions, in the selection of topics for the discussions, and in shaping the follow-up interviews by means of the individualised information that they provided in the previous stages of the project. It allowed the

project in terms of the coverage of the phenomenon. Issues raised by participants were considered during the interpretation of the data and the discussion of the results and findings. In addition, participants had the opportunity at various stages during the project to provide input into the data analysis process and to verify data obtained from the study. Participants made changes where required with the resulting changes being made to data interpretation. The reliability of data obtained was further strengthened by measures such as peer review and pilot testing of measurement instruments, as well as the use of co-coders during data analysis procedures.

6.1.4 Measuring Processes of Change

The aim of this project was to facilitate change in perceptions and to document the processes of change occurring in 14 services across South Australia, from the viewpoint of managers. In order to achieve this, change in perceptions had to be measured. This proved to be a difficult process due to the different stages at which the various organisations were in their own development and processes of change. This difficulty was addressed by the multi-phased design and the use of multiple methodologies that allowed for contextual factors to be considered when data was collected and interpreted. On its own, the mostly statistical data obtained from the questionnaires in the implementation of the pre-post test design, would have been insufficient to capture this complex phenomenon. In addition to this, the timeframe of the project allowed for data collection over a six- month period, in order to accommodate the progressive, dynamic and continually evolving nature of the process of change. The recommendation for future research of this nature is to consider a longer period of time to allow for more changes to occur in practice. The six-month timeframe had the advantage that participants demonstrated clear recall of the focus group discussions, but had the disadvantage of not allowing sufficient time for changes in practice to be implemented by all the services.

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6.1.5 The Use of Online Focus Groups

In general, the choice of using online focus groups was appropriate. Some limitations existed and valuable lessons were learnt regarding the practical application of this relatively new research medium.

6.1.5.1 Quality of Discussion elicited

The use of online focus groups as a communication medium provided some limitations regarding the quality of discussion elicited when compared with face-to-face focus groups. The time lapse between posting a message and waiting for a reply within the week of discussion, resulted in some issues not being fully discussed. It was anticipated that a week of discussion would be sufficient to discuss the topics, but this period may have been too short due to the number of participants participating and the amount of information that was covered in a given discussion. This project had a maximum of seven participants per discussion room, which proved to be adequate to facilitate an active discussion. A recommendation for future research would be not to include more than seven participants and to also consider the nature of the information under discussion as well as the allocated time available for discussion. Less information may have provided more opportunities for in-depth discussion with perhaps an additional discussion session to provide further information. Due to the limited time available to participants, this was not a viable option and neither was the extension of the discussion for another week.

Given the results obtained by means of the indicators, it does illustrate that the change-orientated program was effective in facilitating critical reflection on practice. For the purposes of this project and due to the nature of the information provided, which was mostly factual and introductory, this medium was effective.

6.1.5.2 *Practical Application of Online Focus Groups*

Preparation and planning proved to be essential. A well-developed structure for the discussion was valuable in terms of ordering the discussion. It allowed for participants to be easily orientated when first entering the discussion room and for the discussion to be grouped under the relevant topics. Both of these aspects are essential since information overload is one of the aspects that had to be guarded against when using this medium (McConnell, 1994). In addition, it was essential to prepare the participants to use this medium. Some participants indicated that this was their first experience in using such a medium. Most participants indicated a positive experience in using the medium, with only one experiencing technical difficulties due to her computer set-up.

The system of reminders to participate in the discussion also proved to be valuable. Since participation was reliant on participants having to independently enter the discussion room in their own time, discussion could easily have been hampered. It was recommended that participants enter the site at least three times during the week of the discussion and a system of reminders, that included regular e-mail updates being sent to participants during the discussion week, was used.

6.1.5.3 *Experiences of Participants in using Online Focus Groups*

The experiences of participants varied. Most indicated a very positive experience, while some indicated frustration at not being able to discuss issues face-to-face. These contrasts may suggest links with variations in personal communication styles and familiarity with this communication medium. Participants seemed to value the fact that they could re-visit contributions and respond in their own time, without having to travel anywhere. Future research into the use of this medium is highly recommended, since it is well-suited to some types of research – in this case, the focused discussion of factual data.

All participants commented on the usefulness of the online discussions. As indicated before, country therapists participated more frequently and seemed to have a greater need for discussions with peers. Other participants commented on the value of discussions with peers on a regular basis. It is a recommendation of this research project that a similar discussion forum be developed for therapists to use as a professional peer communication medium. This will provide opportunities for reflection on practice, mentoring, and other support for therapists, and will facilitate a unified approach in practice for occupational therapists.

6.2 RECOMMENDATIONS FOR PRACTICE

The following recommendations for practice can be made as a result of this research project:

6.2.1 Issues identified with regard to Early Intervention Service Delivery

This project indicated managers' perceptions of the major issues in early intervention service delivery related to limited resources, understaffing, long waiting lists and limited services provided to those on waiting lists, as well as insufficient collaboration with the school system. It is recommended that lobbying bodies, such as the Occupational Therapy Association (South Australia) and others, recognise these issues and become actively involved in addressing some of these service delivery issues.

6.2.2 Exploration of the Principles of Best Practice

This project provided a starting point in the development of the principles of best practice for South Australia, as perceived by managers of services. It is recommended that that these principles be investigated further, as suggested by Shonkoff and Meisels (2000). In addition, participants indicated a need for a unified approach amongst occupational therapists (refer Appendix R), hence a set of standards will provide a sound basis for practice.

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6.2.3 The Concept of Early Intervention and its Application in Practice

It is recommended that the concept of early intervention and its application be explored further by therapists in practice, due to the differences experienced in perceptions, applications and priorities of different services. Dialogue amongst services regarding the prioritisation of early intervention services will assist with presenting a unified approach amongst services. This will include a discussion on the proportion of children of school-going age and older children being serviced. Such a discussion forum would be valuable for exploring the different issues involved in service delivery, while a program similar to the change-orientated program utilised during this program, would provide opportunities for exposure to different types of service delivery models. Springfield, Rodger and Maas (1993) recommend that therapists should be aware of the different types of models in order to utilise them flexibly in practice.

6.2.4 The Use of an Online Communication Medium

Consideration can be given to an online communication medium, similar to the one used during this study. A similar professional communication medium is used by the Royal College of Physicians and Surgeons in Ontario, Canada (Whalen & Wright, 2000) and others exist both internationally and nationally. It would be useful to have a South Australian discussion forum for context-specific issues. Such a medium would facilitate ongoing discussion amongst therapists and facilitate critical reflection on practice, which is essential for a developing field such as early intervention.

6.2.5 The Case Management, Consultation and Tele-Rehab Models

The case management, consultation and tele-rehab models should be investigated further with regard to their use and the perceptions held by clinicians concerning these models. This project provided some initial exploration of these models, but indicated

some variations in perceptions and applications in practice that are worth exploring in more depth.

6.2.6 Managers' Time Commitments and Divisions

Time commitments and divisions of managers need to receive some consideration. This project indicated that managers spend most of their time on clinical work. It is recommended that more time be spent on the building of external relations and monitoring the environment. This project has identified these characteristics as not being facilitative of the process of change.

6.2.7 Managers' Training

It is further recommended that management-specific training be provided to managers in order to assist in equipping them for their management duties. This project indicated that most managers have not received any management-specific training, which is not conducive to the facilitation of the processes of change in practice. Training related to financial planning would be beneficial, since managers indicated low levels of comfort in this area. Training and support in aspects of the process of change, such as obtaining resources to facilitate change and to positively influence staff and upper management regarding the processes of change, would be valuable. Other training options are for conflict management, negotiation and strategic management. Training in these areas will improve managers' comfort levels in dealing with these management tasks, which will in turn influence the facilitation of change in their services.

6.3 RECOMMENDATIONS FOR FUTURE RESEARCH

In addition to the more detailed recommendations made in the preceding text as it relates to the specifics of this study, the following recommendations are also made:

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- In order to obtain more in-depth and context-specific information with regard to change in service delivery models, a recommendation for future research is to focus on a smaller number of organisations. Changes could be followed over a longer period of time and methodology could be included to expand on the practical changes occurring – observations and viewpoints of clinicians in specific settings could be included in addition to the perceptions of managers. This will facilitate further exploration of the perceptions related to and the implementation of models such as the case management and team approaches.
- To investigate and expand on the use of online discussion groups as a research medium, building on the valuable lessons learnt from this project.

6.4 CONCLUSION

This project provided valuable information on managers' perceptions of the processes of change occurring in service delivery. It provided context-specific information related to 14 managers' perceptions of early intervention service delivery in South Australia. In addition, it provided information on the application of online focus groups as a research medium. From these aspects, recommendations for practice and future research have been formulated. In conclusion, this project has achieved its overall aim of data collection in order to inform practice.

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Appendix A Consent Form

SCHOOL OF OCCUPATIONAL THERAPY: LETTERHEAD

CONSENT FORM

Project Title:

OCCUPATIONAL THERAPY IN SOUTH AUSTRALIA: A STUDY INTO EARLY INTERVENTION SERVICE DELIVERY

Researcher's name: **Kobie Boshoff**

Supervisor's name: **Erna Alant and Esther May**

- ☐ I have received information about this research project.
- ☐ I understand the purpose of the research project and my involvement in it.
- ☐ I understand that I may withdraw from the research project at any stage.
- ☐ I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential. My employer will only be named if I consent to this and this will be discussed with me.
- ☐ I understand that I will be audio-taped during the interview.

Name of participant:.....

Mailing address:

.....

.....

Telephone:.....

Fax:.....

E-mail address:.....

Signed ..... **Date** .....

I have provided information about the research to the research participant and believe that he/she understands what is involved.

Researcher's signature and date.....

Appendix B Information Sheet

OCCUPATIONAL THERAPY IN SOUTH AUSTRALIA: A STUDY INTO EARLY INTERVENTION SERVICE DELIVERY

This study aims at gaining information regarding the use of current service delivery models in practice and to explore the applicability of other models. It is against the background of various and on-going changes within the context of Occupational Therapy service delivery that this study aims at exploring different options of service delivery in order to meet the ongoing needs of the South Australian society. Occupational Therapy managers of Early Intervention (Paediatric) services are invited to participate in this study.

Due to the nature of this project, the active participation of all participants is essential. This study is based on a participatory action research approach. Participants are actively involved in the process and the researcher acts as facilitator. The study will involve the facilitation of information sessions according to topics regarding service delivery models, that have been identified by participants. It has four phases and it is required that participants commit to the participation in all four phases. Participants are however free to withdraw from the study at any stage without providing a reason.

During the first stage, a questionnaire is completed regarding the current service delivery models in use. This will require 45 minutes to complete and the results will be distributed to managers via mail. During the second phase, managers will get together in a focus group, in the form of an online discussion group. The advantages of using an online discussion group include participation in the discussion in a place and at a time convenient to managers. It also excludes traveling for managers outside of Adelaide. Participants will receive detailed information on the use of online discussion rooms and a secure room will be used.

The first online discussion will focus on the results of the survey and planning of future strategies. As part of the strategic planning, 4 topics will be identified by participants in relation to service delivery and in which participants require more information. Information sessions will then be based on these topics and facilitated by the researcher. Following the first focus group, information sessions will then be conducted according to these topics. These sessions may be presented by members of the focus groups themselves or guest speakers. The final phases will include the completion of a questionnaire and a follow up interview after 2 months.

Each topic will be discussed over the period of a week. Participants will be requested to participate in the discussion at their own time during the week. Topics will be 2 weeks apart. The follow up interviews will be conducted at the Managers' offices or telephonically. The project is expected to commence in early January 2001 and conclude in May 2001.

Confidentiality will be ensured at all times. Your identity will be kept confidential at all times. The name of your employer would be beneficial to understand the results of the study within its context. This issue will however be discussed with each participant and participants will have the choice of keeping the names of their employers confidential. In the case where anonymity is maintained, no reference will be made to specific organizations or individuals when reporting the results of the questionnaire. For the purpose of follow up on incomplete questionnaires or withdrawal of participants at a later stage, a separate cover page will be completed on the questionnaire, with the employer's name on. This sheet will be separated from the questionnaire as soon as the accuracy and completeness of the questionnaire has been established. Participants will have the choice of using their own names or pseudo-names when addressing each other. The online discussions will be transcribed and the transcription, together with other data, stored securely at the University of South Australia. Participants will have the choice of receiving the results of the project.

It is anticipated that this project will provide various benefits to participants and the Occupational Therapy profession. Potential benefits include a better understanding of current service delivery, an opportunity to coordinate services, an opportunity to address problematic issues and to initiate strategies to address these. The study is supported by the Occupational Therapy Association (South Australia).

If you are interested in participating in this research study, please complete the attached consent form and send it to the researcher (envelope and address included). Please note that participation is completely voluntary. Should you require more information, you are welcome to contact the researcher or Esther May at the Occupational Therapy School (8302-2484) for more information. Ethical Approval has been obtained from the Human Research Ethics Committee of the University of South Australia and Ms Linley Hartmann (83020327 or fax: 83020512) is available to discuss any ethical concerns regarding this project.

I look forward to and appreciate your consideration to participate in this project.

Kobie Boshoff

Appendix C Pre-intervention Questionnaire

Appendix D Changes made to the Draft Questionnaire as a Result of the Pilot Test

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Table D1 Changes made to the Draft Questionnaire as a Result of the Pilot Test

Aims of pilot test	Method used	Results of pilot test	Recommendation for changes to questionnaire
To determine the time required to complete the questionnaire.	Timing the completion of the questionnaire during the pilot test.	Time determined as 30 minutes for completion of questionnaire.	Approximate time for completion to be specified as 30 minutes on the cover page.
To determine whether the questions are clearly understood.	Completion of questionnaire by two parties during pilot test.	All questions understood, no misunderstanding. Participants suggested bolding of key words to emphasise the direction of branching questions.	Bolded key word to emphasise direction of branching questions.
To determine whether the order of questions was appropriate.	Completion of questionnaire by two parties during pilot test.	Participants found order to be logical.	No changes made.
To determine the clarity of the instructions provided for completion of each question.	Completion of questionnaire by two parties during pilot test.	Questions were well understood and clear. No uncertainties.	No changes made.
To determine whether response choices are mutually exclusive and exhaustive.	Completion of questionnaire by two parties during pilot test.	"Habituation" was found to be omitted in the question regarding type of service delivery.	"Habituation" included in this question.
Whether the appropriate data is obtained from the questionnaire.	Completion of questionnaire by two parties during pilot test and the trial of data analysis methods.	Uncertainty was observed by one participant regarding the terminology used to describe service delivery models. This participant mentioned that grey areas exist in the list of options provided and that these options may be differently interpreted by respondents due to differences in applications of these models.	An open question was added to provide the opportunity for respondents to describe their service delivery model in their own words. A phrase was added to the cover page to acknowledge the grey areas in the descriptive categories and respondents were asked to select the most appropriate approaches. The definitions of the team approaches were revised to provide more distinct characteristics of each approach. The possibility of different interpretations was considered when analysing the data.
Whether data analysis methods are appropriate.	Trial of the data analysis methods.	Found to be appropriate.	No changes made.
To identify any potential procedural problems.	Completion of questionnaire by two parties during pilot test and the trial of data analysis methods.	Found to be appropriate.	No changes made.

Appendix E Information provided to Participants in Preparation for Participation in Study

OCCUPATIONAL THERAPY IN SOUTH AUSTRALIA: A STUDY INTO EARLY INTERVENTION SERVICE DELIVERY

Information on the use of the online computer conference forum:

This information sheet aims at introducing participants to the online conference as a discussion forum. It aims at making participants feel comfortable with using this medium of communication. Information will be given regarding:

- what online computer conferencing is,
- gaining access to the website,
- an orientation to the discussion room,
- an orientation to the conferences,
- tips on how to use the online conferencing forum,
- steps that are required of you before the conferences start,
- and where to obtain technical support.

What is online computer conferencing?

Online discussion forums provide a common meeting place on the Internet for participants to contribute information. Communication occurs by means of posted messages, which appear in the form of a threaded discussion. Messages are grouped under the same topic heading which makes it possible to follow the different topics within a discussion. Online discussion will occur via asynchronous discussion (discussion which does not occur simultaneously with other participants). This means that participants are not present online at the same time. Participants can however arrange to be present at the same time, but this conversation differs from a synchronous online chat, were the software allows for a rapid exchange of messages between participants. During online conferencing, topics are arranged for intensive discussion during certain periods.

The main advantage of online discussion is the independence of time and travel which are required of face-to-face discussions. Participants can contribute to the discussions any time that is convenient to them. They can access the discussion from anywhere where they can obtain Internet access.

Access to the website:

The online conference is located at the following Internet address:

http://www-p.unisanet.unisa.edu.au/Discussion/Index.asp?SUBJECT=12047&DISC=1712&FR=1

(By copying / entering this address into your "address" box on your Internet Explorer / Netscape Home Page and pressing "Enter", you will be directed to this address. If this is an electronic version of the document, you can click on this address and you will automatically be taken to the address).

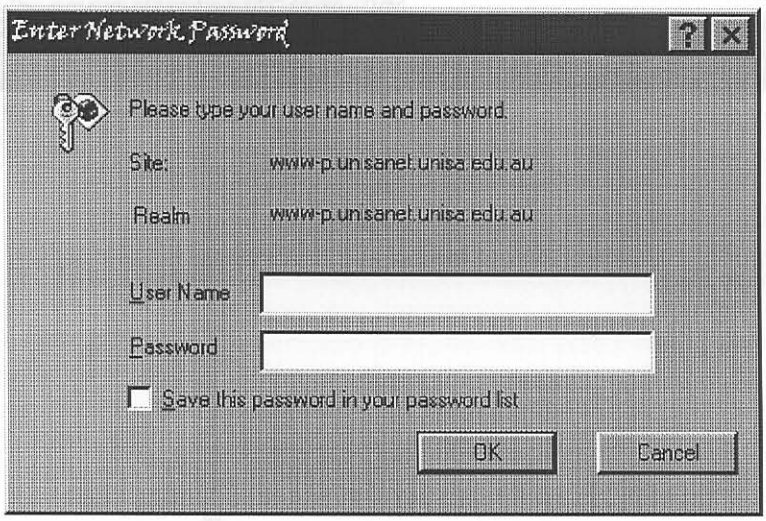
You will now be asked to enter your password to gain access to the site.

Your User Name is: .....

Your Password is: .....

(your password is case sensitive and should be entered in lower case, also the last two are digits)

Enter these in the boxes as shown below and click OK:

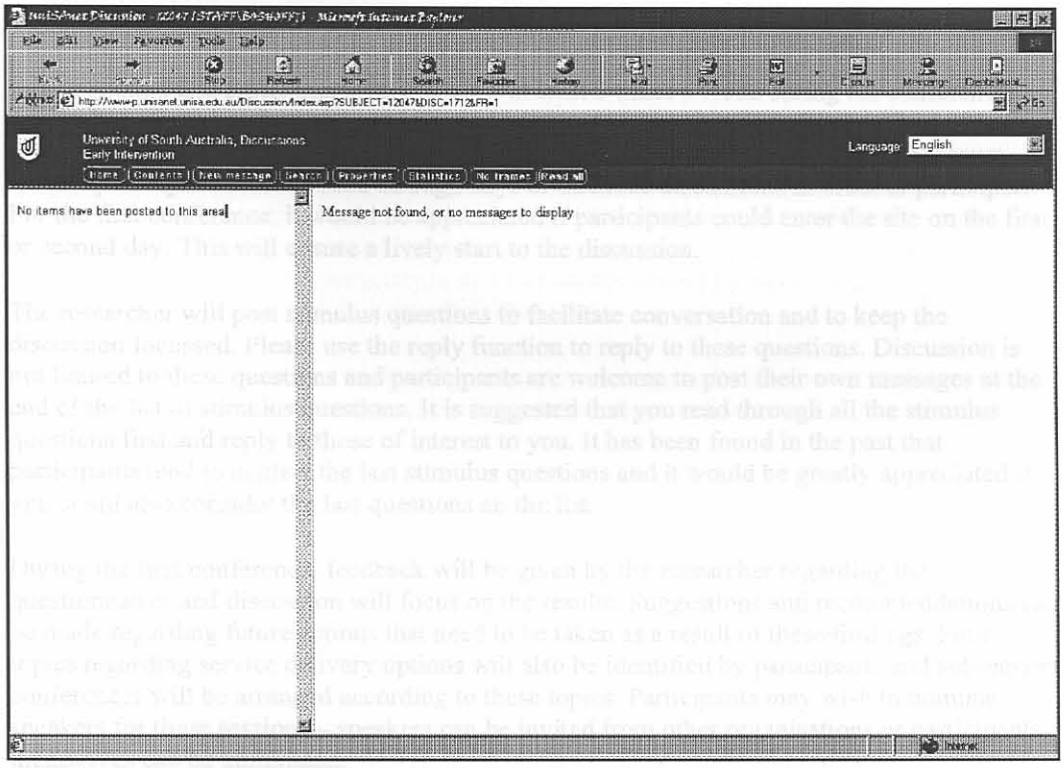


The page that opens up is the discussion page.

If you experience problems with gaining access to the site, please contact the technical support staff who are available to all participants. Contact details can be found at the end of this document.

Orientation to the discussion room:

Below find an illustration of what the discussion room looks like.



The left column indicates the area where the headings of messages appear, as well as the name of the user who has posted the message. You will be able to follow the thread of a discussion by means of this list. By clicking on any given message, opens up the message on the right hand side.

When contributing to the discussion, participants have the choice of either composing a new topic for discussion or replying on someone else's contribution.

When starting a new topic, click on the **"new message"** button at the top of the screen. It is required that you supply a **topic heading** for your message. When selecting a topic heading, take care to provide one which is clear, specific and to the point. After typing your **message** in, read through it again and make sure that it represents accurately what you intended to say. Click the "**Post Item**" button to submit your message.

Participants will mostly use the reply function. When replying to someone else's topic and when responding to the researcher's posted stimulus questions, click on the message you want to reply to, then select the "**reply**" button on the screen. A topic heading is inserted automatically which refers to the previous message. Type in your **message**, double check it and click the "**Post Item**" button.

Participants will be identified by their first names when posting messages. The names will however, not be included in the interpretation and reporting of results as to protect the identity of participants.

Orientation to the conferences:

Participants have a week to participate in a particular conference.

The first conference will be in the week starting the 19/2/00 and ending 23/2/00

It is suggested that participants enter the site at least 3 times a week during the conference weeks, but of course, the more participation occurs, the more it will facilitate a lively discussion. This will also minimise the occurrence of information overload, which occurs when a participant needs to read through days of threaded discussions in order to participate. For the first conference, it would be appreciated if participants could enter the site on the first or second day. This will ensure a lively start to the discussion.

The researcher will post stimulus questions to facilitate conversation and to keep the discussion focussed. Please use the reply function to reply to these questions. Discussion is not limited to these questions and participants are welcome to post their own messages at the end of the list of stimulus questions. It is suggested that you read through all the stimulus questions first and reply to those of interest to you. It has been found in the past that participants tend to neglect the last stimulus questions and it would be greatly appreciated if you could also consider the last questions on the list.

During the first conference, feedback will be given by the researcher regarding the questionnaires and discussion will focus on the results. Suggestions and recommendations can be made regarding future actions that need to be taken as a result of these findings. Four topics regarding service delivery options will also be identified by participants and subsequent conferences will be arranged according to these topics. Participants may wish to nominate speakers for these sessions – speakers can be invited from other organisations or participants themselves can be nominated.

Please find attached the structure that will be used for the first conference. It would help to keep this structure in mind when orientating yourself to the website, since the site may easily look cluttered and overwhelming. This structure make more sense when it has been entered onto the website and made appropriate for the results of the questionnaire.

The subsequent conferences will each be according to a topic as identified in the first conference. A speaker will provide information on a topic in a message format online. The speaker will be available during the week to answer questions and contribute to the discussion.

The second conference will be in the week starting 5/3/00 and ending 9/3/00.

The third conference will be in the week starting 19/3/00 and ending 23/3/00.

The fourth conference will be in the week starting 2/4/00 and ending 6/4/00.

The fifth conference will be in the week starting 16/4/00 and ending 20/4/00.

On the last date of each conference, the researcher will summarise the week's discussion and this will be available for the following week for participants to provide feedback on. This procedure serves as participant verification to ensure that the researcher gives an accurate representation of the discussion. Please enter the site at least once during the alternative weeks to provide feedback on the researcher's interpretation.

You will also receive a short questionnaire to complete after each conference. You will receive it by e-mail as well as fax. You can either complete it electronically and send it back by e-mail/ fax it back or mail it back.

Tips on how to use the online conferencing forum:

Because online discussions are different than face-to-face discussion groups and may be a new communication medium to some participants, the following tips are provided:

Studies with students who have participated in online discussion groups have indicated that the quality of a discussion depends on the students' independence and initiative in entering and participating in the discussion. No structure is provided as is in face-to-face discussions. Some students suggest that participants should plan the times they have available to access the site ahead of time and schedule it into their diaries.

Online discussions have the disadvantage of not providing emotional content and non-verbal responses to a conversation. Try to include these by using terminology like: "Humorous!", "Surprised" and "Exciting!".

For purposes of research, it is important that participants state when they agree with a statement. This can be achieved by replying to a message with the words "I agree" and no further message needs to be attached, if not required.

Take care before submitting your message that the tone of your message is representative of what you mean to say. Without the emotional and non-verbal clues, a message can easily sound cold, formal or directive.

Also ensure that your message will be understood in the correct context by others. Provide sufficient information in your message to set the context for other readers.

Some find it difficult to follow the discussion on a computer screen and it may be useful to print out the messages first and take your time to respond to them.

Steps required of participants before the first online conference:

In order to ensure that all technical problems are sorted out before the first conference begins and to familiarise all participants with the site, it is requested that all participants enter the site before the first conference.

You can enter the site as from: 1 February 2001.

After entering the site, leave your first message in the form of a greeting to the other participants. In this way, the researcher can verify that all participants have successfully entered the site and are familiar with the process of creating a message.

Technical support

Technical support staff are available to participants at any stage during the project. They can be contacted at:

Telephone: 08 - 8302 5000

E-mail: HelpDesk@Unisa.edu.au

I wish to thank all participants for their willingness to try out this new way of conducting focus groups and look forward to meeting you all online.

I will also be available at the following contact details:

Tel: 83000186

E-mail: kobieboshoff@hotmail.com

Regards

Kobie Boshoff

Appendix F Information provided to Guest Speakers in Preparation for Online Discussion

Dear .....

Thank you very much for your willingness to participate as guest speaker in one of our online computer conferences regarding Early Intervention (Paediatric) service delivery in South Australia. Please find herewith some information on

- what online computer conferencing is,
- gaining access to the website,
- an orientation to the discussion room,
- an orientation to the conferences,
- tips on how to use the online conferencing forum,
- steps that are required of you before the conference starts,
- and where to obtain technical support.

What is online computer conferencing?

Online discussion forums provide a common meeting place on the Internet for people to contribute information. Communication occurs by means of posted messages, which appear in the form of a threaded discussion. Messages are grouped under the same topic heading which makes it possible to follow the different topics within a discussion. Online discussion will occur via asynchronous discussion (discussion which does not occur simultaneously with other participants). This means that participants are not present online at the same time. Participants can however arrange to be present at the same time, but this conversation differs from a synchronous online chat, were the software allows for a rapid exchange of messages between participants. During online conferencing, topics are arranged for intensive discussion during certain periods.

The main advantage of online discussion is the independence of time and travel which are required of face-to-face discussions. Participants can contribute to the discussions any time that is convenient to them. They can access the discussion from anywhere where they can obtain Internet access.

Access to the website:

The online conferences are located at the following Internet address:

http://www-p.unisanet.unisa.edu.au/Discussion/Index.asp?SUBJECT=12047&DISC=1712&FR=1

(Metro group)

http://www-p.unisanet.unisa.edu.au/Discussion/index.asp?SUBJECT=12047&DISC=1725&FR=1

(Country group)

(By copying / entering this address into your "address" box on your Internet Explorer / Netscape Home Page and pressing "Enter", you will be directed to this address. If this is an

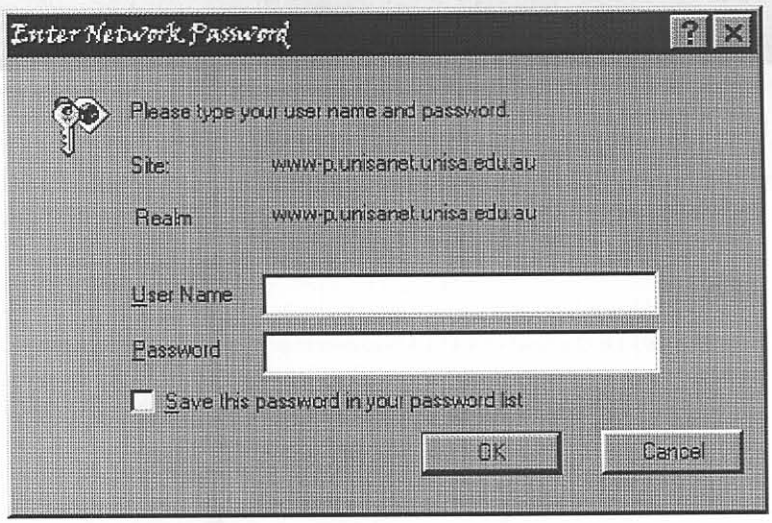
electronic version of the document, you can click on this address and you will automatically be taken to the address).

You will now be asked to enter your password to gain access to the site. Your User Name is: guest speaker

Your Password is: .....

(your password is case sensitive and should be entered in lower case, also the last two are digits)

Enter these in the boxes as shown below and click OK:

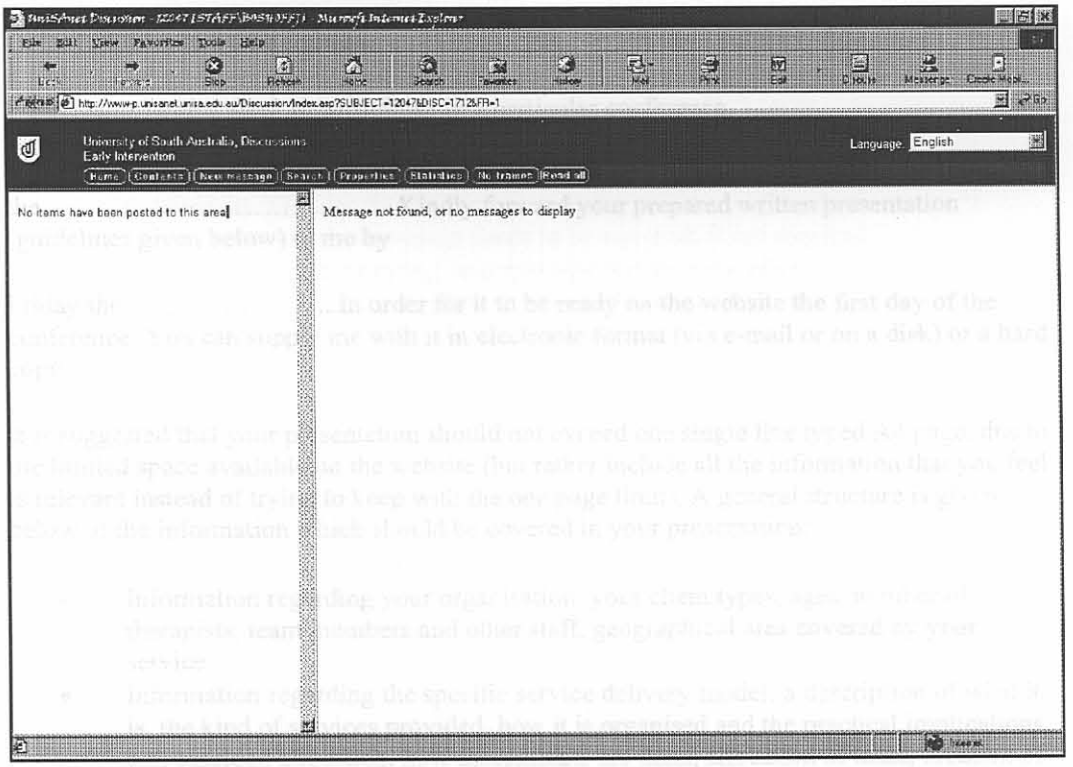


The page that opens up is the discussion page.

If you experience problems with gaining access to the site, please contact the technical support staff who are available to all participants in this research project. Contact details can be found at the end of this document.

Orientation to the discussion room:

Below find an illustration of what the discussion room looks like.



The left column indicates the area where the headings of messages appear, as well as the name of the user who has posted the message. You will be able to follow the thread of a discussion by means of this list. By clicking on any given message, opens up the message on the right hand side.

When contributing to the discussion, you have the choice of either composing a new topic for discussion or replying on someone else's contribution.

When starting a new topic, click on the **"new message"** button at the top of the screen. It is required that you supply a **topic heading** for your message. When selecting a topic heading, take care to provide one which is clear, specific and to the point. After typing your **message** in, read through it again and make sure that it represents accurately what you intended to say. Click the "**Post Item**" button to submit your message.

When replying to someone else's topic and when responding to the researcher's posted stimulus questions, click on the message you want to reply to, then select the "**reply**" button on the screen. A topic heading is inserted automatically which refers to the previous message. Type in your **message**, double check it and click the "**Post Item**" button.

Participants will be identified by their first names when posting messages. The names will however, not be included in the interpretation and reporting of results as to protect the identity of participants. Guest speakers will be identified as "Guest Speaker" and you can will need to include your name in the message that you post, the same as when you end of a letter.

Orientation to the conferences:

Participants have a week to participate in a particular conference.

The conference in which you have agreed to act as guest speaker, will be in the week starting the ..... Kindly forward your prepared written presentation (guidelines given below) to me by

Friday the ....., in order for it to be ready on the website the first day of the conference. You can supply me with it in electronic format (via e-mail or on a disk) or a hard copy.

It is suggested that your presentation should not exceed one single line typed A4 page, due to the limited space available on the website (but rather include all the information that you feel is relevant instead of trying to keep with the one page limit). A general structure is given below of the information which should be covered in your presentation:

- Information regarding your organisation: your client types, ages, number of therapists, team members and other staff, geographical area covered by your service.
- Information regarding the specific service delivery model: a description of what it is, the kind of services provided, how it is organised and the practical implications, e.g. caseload allocation, how assessments are done, allocation of tasks, location of services.
- The things that work well with this service delivery model for your organisation.
- The things that do not work all that well with this service delivery model for your organisation.
- Other appropriate information that you feel is relevant to this topic.

As discussed, it would be greatly appreciated if guest speakers are available during the conference week to answer questions and participate in the discussion. It is suggested to enter the site at least 3 times a week, but of course, the more participation occurs, the more it will facilitate a lively discussion. This will also minimise the occurrence of information overload, which occurs when a person needs to read through days of threaded discussions in order to participate.

The researcher will post stimulus questions to facilitate conversation and to keep the discussion focussed. Please use the reply function to reply to these questions. Discussion is not limited to these questions and participants are welcome to post their own messages at the end of the list of stimulus questions. It is suggested that you read through all the stimulus questions first and reply to those of interest to you. It has been found in the past that participants tend to neglect the last stimulus questions and it would be greatly appreciated if you could also consider the last questions on the list.

Tips on how to use the online conferencing forum:

Because online discussions are different than face-to-face discussion groups and may be a new communication medium to some participants, the following tips are provided:

- Studies with students who have participated in online discussion groups have indicated that the quality of a discussion depends on the students' independence and initiative in entering and participating in the discussion. No structure is provided as is in face-to-face discussions. Some students suggest that participants should plan the times they have available to access the site ahead of time and schedule it into their diaries.
- Online discussions have the disadvantage of not providing emotional content and non-verbal responses to a conversation. Try to include these by using terminology like: "Humorous!", "Surprised" and "Exciting!".
- For purposes of research, it is important that participants state when they agree with a statement. This can be achieved by replying to a message with the words "I agree" and no further message needs to be attached, if not required.
- Take care before submitting your message that the tone of your message is representative of what you mean to say. Without the emotional and non-verbal clues, a message can easily sound cold, formal or directive.
- Also ensure that your message will be understood in the correct context by others. Provide sufficient information in your message to set the context for other readers.
- Some find it difficult to follow the discussion on a computer screen and it may be useful to print out the messages first and take your time to respond to them.
- Steps required before the online conference.

In order to ensure that all technical problems are sorted out before the online conference and to familiarise yourself with the site, it is suggested that you enter the site before the conference.

Technical support

Technical support staff are available to participants at any stage during the project. They can be contacted at:

Telephone: 08 - 8302 5000

E-mail: HelpDesk@Unisa.edu.au

I will also be available at the following contact details:

Tel: 83000186

Fax: 83833290

E-mail: kobieboshoff@hotmail.com

Regards

Kobie Boshoff

Appendix G Bracketing exercise

Potential assumptions which may impact on the research project's results:

- That services need to change.
- That services do not realise that they need to change.
- That services' managers have limited business management skills and training.
- That services do not use management theory principles.
- That services do not use strategic planning.
- That services are not innovative in terms of service delivery options.
- That the researcher has the answers to their service delivery problems.

Strategies to address the assumptions:

That services need to change and that they do not realise that they need to change:

- By not accepting the viewpoint that all services need to change.
- By using pre-set indicators which are concrete and objective in their assessment of change.
- By acknowledging that managers know their services best.
- By maintaining a neutral stance.
- By analysing evidence within the context of each service.

That services' managers have limited business management skills and training/ that they do not use management theory principles/ that they do not use strategic planning/ that services are not innovative in terms of service delivery options:

- By not accepting the stated viewpoints without evidence – utilising concrete and objective assessment indicators.
- By including the active participation of managers during the project.
- By acknowledging and respecting their contributions.
- By involving them as "guest speakers".
- By acknowledging that they know their services best.
- That the researcher has the answers to their service delivery problems
- By acknowledging that they know their services best.
- By including the active participation of managers during the project.

In general:

- Consideration given to the researcher's bias/ assumptions when interpreting and reporting results.
- Give adequate opportunity for member checks.
- Acquire and utilise adequate contextual information regarding each service.
- Careful consideration given to the researcher's role in the project:
    - Unbiased participation in focus groups/ not as "expert".
    - Supportive and encouraging approach during focus groups.
    - Be "one of them" during focus groups.
    - Not enforce change, but only provide information, document process and measure change against criteria.

Appendix H Extract from Journal

28/4/00

After discussion with MS, decided to have a look at participatory action research (PAR) more closely as methodological approach – my study does not seem to fit into Grounded Theory as such – does not investigate a social issues (which forms the basis of Grounded Theory). My aim is more to facilitate change and empowerment by actively involving participants in the process. Therefore: PAR.

Still possible to combine PAR and Grounded Theory? I like the following aspects of Grounded Theory:

The process of saturation – doing data analysis while doing data collection and going back to conduct more interviews where necessary.

Also comparative analysis technique: a structured way to interpret qualitative findings.

Appendix I First Online Focus Group: Short Questionnaire

OCCUPATIONAL THERAPY IN SOUTH AUSTRALIA: A STUDY INTO EARLY INTERVENTION SERVICE DELIVERY

Instructions for completion:

If you are completing this form electronically, **bold** the number in order to indicate your choice

Your options for returning this form:

E-mail (kobieboshoff@hotmail.com)

Fax: 08-8373 3290

Mail: Kobie Boshoff, Occupational Therapy School, UniSA, GPO Box 2471, Adelaide, 5001

DATES OF ONLINE CONFERENCE:

1. Please indicate the degree to which you have found this week's focus group worthwhile:

Not worthwhile at all	Not worthwhile	Average	Worthwhile	Very worthwhile
1	2	3	4	5

Comments:

2. Please indicate the degree to which you have found the presentation of the results:

- Regarding the way in which the information was presented:

Not clear at all	Somewhat clear	Average	Clear	Very clear
1	2	3	4	5

Comments:

- Regarding the layout of the information on the website:

Not clear at all	Somewhat clear	Average	Clear	Very clear
1	2	3	4	5

Comments:

- Regarding the selection of the information which was presented:

Not appropriate at all	Somewhat appropriate	Appropriate	Appropriate	Very appropriate
1	2	3	4	5

Comments:

3. Can this information be applied to your work setting: Yes / No

Please describe

4. Please indicate on the scale your experience of using this week's online computer conferencing as discussion forum:

Very negative	Negative	Average	Positive	Very positive
1	2	3	4	5

Comments:

5. Any additional information that you would like to provide regarding this week's focus group:

Appendix J Online Focus Groups 2 – 5: Short Questionnaire

OCCUPATIONAL THERAPY IN SOUTH AUSTRALIA: A STUDY INTO EARLY INTERVENTION SERVICE DELIVERY

Instructions for completion:

- If you are completing this form electronically, **bold** the number in order to indicate your choice
- Your options for returning this form:

E-mail (kobieboshoff@hotmail.com)

Fax: 08-8373 3290

Mail: Kobie Boshoff, Occupational Therapy School, UniSA, GPO Box 2471, Adelaide, 5001

TOPIC:

DATE OF CONFERENCE:

1. Please indicate the degree to which you have found this week's focus group worthwhile:

Not worthwhile at all	Not worthwhile	Average	Worthwhile	Very worthwhile
1	2	3	4	5

Comments:

2. Please indicate the degree to which you have found the presentation of the information by the guest speaker:

- Regarding the way in which the information was presented

Not clear at all	Somewhat clear	Average	Clear	Very clear
1	2	3	4	5

Comments:

- Regarding the layout of the information on the website:

Not clear at all	Somewhat clear	Average	Clear	Very clear
1	2	3	4	5

Comments:

- Regarding the selection of the information which was presented:

Not appropriate at all	Somewhat appropriate	Appropriate	Very appropriate
1	2	3	4

Comments:

Regarding the interaction with the guest speaker:

Not good at all	Below average	Average	Good	Very good
1	2	3	4	5

Comments:

3. Can this information be applied to your work setting currently?

No, not at all	No not currently, but possibly in the future	Unsure, but I will give it further consideration	Yes, with some modifications	Yes, it can be applied as it was presented
1	2	3	4	5

4. Do you foresee difficulties in applying this model in your work setting currently: Yes/ No

If yes: What are the difficulties you foresee applying this model in your work setting currently:

Support of upper management	Support of staff	To develop strategies to apply the model	To mobilise resources to apply the model	Unsure
1	2	3	4	5

Comments

5. To implement this model would you require more information? Yes/No

6. Please indicate on the scale your experience of using this week's online computer conferencing as discussion forum:

Very negative	Negative	Average	Positive	Very positive
1	2	3	4	5

Comments:

7. Any additional information that you would like to provide regarding this week's information session:

Appendix K First Online Focus Group: Content Analysis

CONTENT ANALYSIS OF FIRST ONLINE CONFERENCE:

General impressions / info on services and participation:

- 12 services participated in the discussion
- Participation occurred predominantly during standard office hours
- The country group seemed to be more active than the metropolitan group
- 2 services reported new paediatric service delivery
- 2 services reported new temporary funding obtained for existing paediatric services

RESULT 1: LIMITED RESOURCES

Description of results:

Context of this result:

- Inadequate funding of new services from the start
- Annual budget cuts for existing services
- Country group reports that most of their services originate out of Domiciliary Care Services with funding directed towards the aged population. Over the years, small percentages of funds and time have been allocated towards paediatric
- Country group: sole paediatric services in large areas, with other clinical cases on caseloads

Reasons:

- Historical: OTs were not as active as Speech Pathologists in lobbying for services
- Difficult to illustrate the link between our services and the outcomes

Consequences:

- Understaffing
- Limited services provided: limited areas, limited age groups, limited venues (eg school based), limited opportunities to develop relationships with other agencies eg DETE, time limitations for intervention
- Long waiting lists
- Families travelling from far for services – inequity and access issues
- Therapists feeling frustrated, burnt out
- Therapists feeling that they are providing incomplete services

Past and current actions taken:

- Lobbying for paediatric services: regional boards and government, upper management, Department of Human Services. E.g. AAOT SA: lobbying relevant Members of Parliament
- Applying for grants
- Strengthening links with other agencies which may be future employers of OTs, e.g. DETE
- Participation in regional forums and networks
- Strategic use of final year OT students
- Feedback from consumers and the need for services and presentation to upper management
- Use of media to promote OT
- Apply for extra funds
- Use of lobbying bodies, e.g. parent groups and other community groups to strengthen the case for OT services
- Unit planning days

Possible strategies (may overlap with "Past actions taken"):

- Promotion of OT in EI
- Strong representation at and presentation to the upper management levels
- State wide appeal, introducing OT to politicians, government
- Regional forums: identify needs, statistics
- A unified, coordinated approach from all EI services
- E-mail distribution lists
- Audio conferences (one existing in North Western country area)
- Use of lobbying bodies, e.g. parent groups and other community groups to strengthen the case for OT funding
- Sharing of resources: sharing treatment facilities, run joint programmes, joint in-services
- Shared resource preparation especially health promotion
- Develop joint funding grants and providing support for each other in writing funding grants
- For country OTs: consider working on/ lobbying for transferring Domiciliary Care funds into paediatric
- Consider fee for service process
- Creative exploration of ways in which services are provided
- Consider changing focus from individual treatment focussed to a community development model

Other discussion/ impressions:

- Frustration with limited resources apparent in the discussion
- Continual referral to Speech Pathologists and their effective way of lobbying for their services

RESULT 2: UNDERSTAFFING

Description of results:

Context of this result:

- Related to limited resources: not about limited number of OTs
- No services to refer on to once children become school aged; the need for continuation of services once they reach school age (compared to Speech Pathologists in schools that take on clients once they reach school age)
- Country therapists reported
- Difficulty in attracting experienced paediatric therapists to their region which decreased efficiency
- Difficulty in the retention of experienced OTs

Consequences:

- Limited services provided to school aged children in lieu of EI as a priority
- Limited time to spend on research and health promotion projects

Past actions taken:

- Changes in service delivery: groups, home programmes, intervention "blocks"
- Use of volunteers (some difficulties with time spent on training, keeping trained volunteers and finding suitable volunteers)
- Use of "peer group leaders", i.e. past parents in intervention
- Prioritising caseloads: school aged children lowest priority
- Use OT assistant more
- Trialing different caseload management strategies
- Collecting data re waiting list and need to present to upper management

Possible strategies (may overlap with "Past actions taken"):

- Use of waiting list statistics to provide evidence of the need for more staff
- More strategic use of OT assistants: look at role of OT assistants carefully

Other discussion/ impressions:

- Therapists feel dissatisfied with their services to clients

RESULT 3: LONG WAITING LISTS AND SERVICES TO CLIENTS ON WAITING LISTS

Description of results:

Context of this result:

- Hospital services report that they receive more referrals when other services tighten their service criteria
- Public becoming more aware of importance of EI

Reasons:

- Inadequate resources
- No service to refer on to once children reach school age
- Lack of time to deal with current caseloads

Consequences:

- Limited/no services to clients on waiting lists
- Unhappy clients on waiting list
- Poor reputation with other service providers
- Increased pressure on staff
- Decreased work satisfaction
- Potentially increased difficulties with staff retention

Past actions taken:

- Review of current service delivery policy and implementation of policy based on service provision limitations
- Refer to private therapists for those with private cover
- Suggest initial assessment by private therapist while on waiting list
- Use of groups to work through current cases faster
- Country group reports that groups are not always the answer to them, since they lack numbers with the same needs to form groups
- Increased emphasis on parent participation in home programmes
- Increased emphasis on schools to provide support for school programmes following consultancy with appropriate staff
- Temporary increase in staffing to work through waiting list

Current actions:

- Drawing booklet with simple ideas for families on how to encourage drawing and participation in these activities at home
- Prioritising clients
- Modified reports (shortened) and use of pre-set report format
- Modified procedures at referral: immediate assessment with booking into a coming "intervention block"
- Keep statistics on waiting list and report to higher management

Possible strategies (may overlap with "Past actions taken"):

- Focus more on health promotion to eliminate waiting lists in the first place (on the long term): raising community awareness in terms of child development, etc.
- Gradual increase of health promotion component over the coming years
- Pre-developed, generic development stimulation programmes: perhaps the use of 401 Community fieldwork OT students
- A short educational programme for parents of children on waiting list
- Consultation model of service delivery

RESULT 4: INSUFFICIENT COLLABORATION WITH SCHOOL SYSTEM

Description of results:

Context of this result:

- No DETE funding for services, compared to Speech Pathologists

Consequences:

- Limited school visits: some services only attending meetings
- Limited contact with teachers: phone conversations mainly
- Limited services: the need of observation for assessment purposes, for some children goes unmet

Current actions taken:

- Educational presentations to DETE (new project)
- Project officer at … working on allied health links with DETE
- Mostly consultation services
- Workshops run for teachers and school support officers
- Work through reports and recommendations with teachers to increase understanding of OT services and child development
- Health Promotion package developed by 401 OT students in the country area on fine motor skills

Possible strategies (may overlap with "Current actions taken"):

- Consider where OTs want to position themselves within the school system: to be employed by DETE or deliver services to DETE from external?
- Promotion of OT to schools, so that the push for OT services comes from within DETE
- Possibility of using Partnership 21 to get into schools
- Education of teachers re role of OT, referral criteria
- Booklet produced by OT 401 students: "Ideas for Schools"
- Key stations at schools
- Advantage of working in schools: school aged children seem to require less intensive intervention: can be provided with programmes (followed through by school support officers) and regularly reviewed

Other discussion:

- Many services have reported very good results with the limited collaboration they have had so far: teachers seem to be supportive and enthusiastic in general, good responses from teachers
- Some reported difficulties, e.g. limited equipment and space to work, having to fit into the school system's programme, difficulty in communicating with teachers, limited parent involvement, some reported limited receptivity from teachers and incorporating suggestions into the class
- Kindergartens seem to be more open for OT involvement and parent involvement much better

FUTURE TOPICS OF FOCUS GROUPS:

- Maroondah Approach to Clinical Services
- Health promotion as a way of raising OTs profile in the community
- Adult/Child models/programmes
- Service delivery to schools: developing a unified approach
- EI service delivery: The need for OTs to position themselves in the area of EI.

Appendix L Analysis of discussions of First Online Focus Group: Examples of Evidencing Statements

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Table L1 Analysis of First Online Focus Group: Examples of Evidencing Statements

Pre-set Indicator	Example of statement	Comments
Critical reflection regarding current models.	"It has been fantastic to get to know teachers…running programs at the schools with them as co-leaders…the only problem now is that I am concerned that we are spending too much time with school aged children, when our whole push is to move the service towards health promotion, early intervention and away from direct intervention! "	For both metro and country groups this was the indicator with the most evidence which shows that both groups participated in a high level of critical reflection.
Evidence of identification of the need for change in current service delivery models.	"…perhaps we need to bite the bullet with service delivery and have a planned strategy for gradually increasing the health promotion components to our jobs."	Both groups indicated a strong need for change with the country group indicating this indicator as the second most prevalent and the metro group the third most prevalent.
Evidence of identification of problems related to current service delivery models.	"We feel understaffed because of our high case loads, complex needs of many clients, lack of clerical support and heavy demands from management."	The identification of the problem is the first step in the change process, as discussed in Chapter 3. Both groups indicated that they identified with problematic issues that were indicated by the baseline questionnaire. Twenty entries in the country group referred to the identification of problems related to current service delivery models. Ten entries in the metropolitan group indicated a strong identification with the problems, since it is the indicator with the second largest number of entries.
Evidence of openness for new ideas/ alternative strategies and models.	"Barbara's strategy of working with the school staff to train them up in running handwriting programs is excellent…"	Both groups showed relatively high evidence of openness for new ideas, ranking third overall for both groups.
Evidence of insight into the need for strategical planning, including the need to analyse external and internal environments of services.	"It wasn't until our recent, more pro-active association with the schools…that the schools have realised what a valuable resource we are..."	Both groups provided evidence of viewing strategic planning as important.
Active participation in discussion.	"Can someone describe how they effectively use aide time?"	This indicator was one of the highest in the country group, but one of the lowest in the metro group. As mentioned before, the country group participated much more in this discussion than the metro group which was evidenced in the number of entries.

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Table L1 Continued

Pre-set Indicator	Example of Statement	Comments
Evidence of understanding the nature of the problem: insight into the deficiencies of current models of practice.	"The long waiting time is caused by a lack of time to deal with current caseload."	Understanding the problem follows as next step after problem identification in the change process. Both groups showed some evidence of understanding the nature of the problems.
Motivation to learn, interest in information and attention given.	"Yes! I agree, we need to be a "unified" group and lobby loudly and in an organised way." "I think this is just great!" and "I like the idea of a unified approach!"	This indicator was one of the highest in the country group, while it was one of the lowest in the metro group.

Appendix M First Online Focus Group: Short Questionnaire – Raw Data

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Table M 1 Responses to Short Questionnaire: Focus Group 1

Question	Rating categories with corresponding number of responses				
	1	2	3	4	5
Degree to which focus group was found to be worthwhile	Not worth-while at all 0	Not worth-while 0	Average 2	Worth-while 4	Very worth-while 1
Degree to which the presentation of the information was clear	Not clear at all 0	Somewhat clear 1	Average 1	Clear 5	Very clear 0
Degree to which the layout of information on website was found to be clear	Not clear at all 0	Somewhat clear 1	Average 2	Clear 4	Very clear 0
Degree to which the selection of information which was presented, was appropriate	Not appro-priate at all 0	Somewhat appropriate 1	Appropriate 1	Appropriate 5	Very Appro-priate 0
Participants' experience of using the online computer conferencing forum	Very negative 0	Negative 0	Average 1	Positive 5	Very Positive 1
N=7					

Appendix N Online Focus Groups 2 – 5: Short Questionnaire – Raw Data

Table N 1 Short Questionnaire administered after each focus group: Responses to Question "Please indicate the degree to which you have found this week's focus group worthwhile"

Scale:				
Not worthwhile at all	**Not worthwhile**	**Average**	**Worthwhile**	**Very worthwhile**
1	**2**	**3**	**4**	**5**
Responses:				
0	2	7	9	2

N= 20

Table N 2 Short Questionnaire administered after each focus group: Responses to Question "Please indicate the degree to which you have found the presentation of the results: Regarding the way in which the information was presented"

	Scale																			
	1				**2**				**3**				**4**				**5**			
	Not clear at all				Somewhat clear				Average				Clear				Very clear			
Focus Groups 2 – 5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5
Number of responses	0	0	0	0	0	0	0	0	0	1	0	0	6	3	3	3	2	1	0	1
Total for each scale item	0				0				1				15				4			

N=20; FG2 = 8; FG3 = 5; FG4 = 3; FG5 = 4

Table N3 Short Questionnaire administered after each focus group: Responses to Question "Please indicate the degree to which you have found the presentation of the results: Regarding the layout of the information on the website"

	Scale																			
	1				2				3				4				5			
	Not clear at all				Somewhat clear				Average				Clear				Very clear			
Focus Groups 2 – 5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5
Number of responses	0	0	0	0	0	0	0	0	3	3	2	1	4	1	1	3	1	1	0	0
Total for each scale item	0				0				9				9				2			

N= 20; FG2 = 8; FG3 = 5; FG4 = 3; FG5 = 4

Table N4 Short Questionnaire administered after each focus group: Responses to Question "Please indicate the degree to which you have found the presentation of the results: Regarding the selection of the information which was presented"

	Scale															
	1				2				3				4			
	Not appropriate at all				Somewhat appropriate				Appropriate				Very appropriate			
Focus Groups 2 – 5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5
Number of responses	1	0	0	0	1	0	2	1	6	3	1	1	0	2	0	2
Total for each scale item	1				4				11				4			

N= 20; FG2 = 8; FG3 = 5; FG4 = 3; FG5 = 4

Table N5 Short Questionnaire administered after each focus group: Responses to Question "Please indicate the degree to which you have found the presentation of the results: Regarding the interaction with the guest speaker"

Focus Groups 2 – 5	Scale																			
	1				2				3				4				5			
	Not good at all				Below average				Average				Good				Very Good			
	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5
Number of responses in this category	0	0	0	0	1	2	0	1	0	1	1	0	6	1	2	3	0	1	0	0
Total for each scale item	0				4				2				12				1			

N= 20; FG2 = 8; FG3 = 5; FG4 = 3; FG5 = 4

Table N6 Short Questionnaire administered after each focus group: Responses to Question "Please indicate on the scale your experience of using this week's online computer conferencing as discussion forum"

Focus Groups 2 – 5	Scale																			
	1				2				3				4				5			
	Very negative				Negative				Average				Positive				Very Positive			
	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5	2	3	4	5
Number of responses in this category	0	0	0	0	0	0	0	0	4	3	2	1	3	1	1	2	0	1	0	1
Total for each scale item	0				0				11				6				2			

N= 20; FG2 = 8; FG3 = 5; FG4 = 3; FG5 = 4

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 proformas 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 predetermined 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 on 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

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 re 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 groups 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/carers. 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 it's 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 stonger 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 ½ 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, 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.

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 0.5 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.

Appendix P Analysis of Follow-up Interviews: Examples of Evidencing Statements related to Pre-set Indicators

Table P 1 Follow-up Interviews: Evidence of Pre-set Indicators

Indicator	Example of statement
Evidence of openness for new ideas/ alternative strategies and models.	"Looking at other services interstate and using that to set up our service for the future."
Evidence of critical reflection regarding models.	"I am getting much better results/ outcomes than a few years ago under other models."
Evidence of identification of the need for change in current service delivery models.	"So, what we need is a better system."
Evidence of understanding the nature of the problem - insight into the deficiencies of current models of practice.	"…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."
Evidence of commitment to change.	"Most of us are now moving more away from direct therapy to more collaborative approaches."
Evidence of insight into the need for strategical planning, including the need to analyse external and internal environments of services.	"So there was all this external stuff going on..."
Evidence of internalisation of information presented in focus groups.	"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."
Actions taken / effort regarding the implementation of changes in terms of: Workforce development or changes. Organisational and / or procedural development or changes. Resource allocation or applied for funding to implement changes: financial, equipment, workspace. Development of partnerships and networks.	"So at least I was very keen to get at least the timetabling part of it underway for all of us."
Evidence of: a synthesis of old and new views, that is the use of certain new concepts of a different model combined with current practice. a decision made to negate current views regarding current service delivery models and moving onto a different model.	"We are just going to take parts of it."

Appendix Q Analysis of Follow-up Interviews: Examples of Evidencing Statements regarding Best Practice Principles

Table Q1 Evidencing Statements regarding Best Practice Principles

Service Delivery Model	Number of references	Rating according to prevalence	Relevant statements
Early intervention, prevention and client education	7	1	"Its 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."
Client / family centred services	5	2	"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."
Use of support staff, multi-skilling and personnel substitution	4	3	"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…"
One to one, direct service delivery	3	4	"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." 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.
Health promotion	3	4	"Moving more to the Primary Health Care."
Intervention in functional environments	3	4	"To get that transfer of learning to other environments… not have intervention in isolation… do intervention in realistic environments."

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Table Q1 Continued

Service Delivery Model	Number of references	Rating according to prevalence	Relevant Statements
The community based approach	3	4	"I strongly believe that best practice is relevant to individual communities…" "…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." "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."
Groups	2	5	"Groups…to be time efficient within limited resources. Groups are still a good way of delivering services… "
Collaborative consultation	2	5	"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."
Centre based services	1	6	"…because parents benefit from social integration. Also for therapists."
Trans-disciplinary teamwork	1	6	"… using the Trans-disciplinary Approach."
Interagency collaboration	1	6	"It would be good if there is more collaboration of services among agencies – come to some sort of agreement…"
Case management	0	7	N/a
Multi-disciplinary teamwork	0	7	N/a
Inter-disciplinary teamwork	0	7	N/a
Tele rehab / health	0	7	N/a

Appendix R Additional Statements related to Occupational Therapy Services in general

Additional Statements related to Occupational Therapy Services obtained from Interviews:

In addition to the information obtained, specifically related to service delivery, statements were also made by participants which relate to general strategies for the Occupational Therapy profession as a whole. These include:

- The lack of a unified approach used by all OT services.
- The delivery of joint projects related to intervention provided by OTs in collaboration with the educational system. It is felt that OTs will be able to make a bigger statement in facilitating their involvement with the educational system if they do it in a unified manner.
- The value of having standards of practice and a unified approach for OTs working in schools were mentioned. Another service indicated the lack of standards of practice for paediatric service delivery in general. The introduction of minimum standards as a proposal to the OT Association was mentioned.
- The value of a communication network for OTs was suggested to facilitate a more unified approach in terms of service delivery across the state. The OT Association was mentioned as a possible initiator of such a network.
- The value of a more formalised mentoring network for OTs was mentioned.
- The value of having a team specific strategic plan which links in with the organisation's overall direction. One service emphasised the need for OTs to make time to plan and not only spend time on clinical service delivery.
- The collection and use of statistical evidence of the impact of financial cuts on services when lobbying for more financial resources.
- The importance of persistent lobbying for resources.
- The need to raise community awareness of the need for OT services.
- The need for guidelines in terms of boundaries for multi-skilling of other therapists and support staff. A service indicated a concern in regards to this and that guidelines would provide boundaries for OTs in terms of effective use of this strategy without compromising the profession's identity.
- The different viewpoints of OTs on Early Intervention as priority in service delivery compared to services to school aged children, was mentioned.
- One service mentioned that it was a valuable experience to develop strong links and working relationships with the manager of special education services in the area. The manager of special education is the person who has the power to allocate funds.
- One service had the example of a social planning alliance which had been developed that involves different sectors including health and education.
- One service mentioned that by saying a new project is a trial provides the opportunity to learn through it, without putting additional pressures on staff for achieving outcomes in the initial phases of a new project.
- The limited training available and supervision of new paediatric OTs and the suggestion of more guided post-graduate paediatric-specific educational courses for OTs.

Appendix S Additional Statements related to Best Practice Principles

Additional Statements related to Best Practice Principles

- That best practice is relevant to individual communities and that no one model can be relevant to all communities.
- The importance of using a combination of models and not only concentrate on one to one, direct service delivery.
- The value of evidence based intervention.
- Intervention which is based on outcomes measures.
- The use and quotation of research in order for practice to be grounded.
- Best practice is about being an advocate for families.
- Best practice depends on the type of caseload.
- The provision of regular, consistent practice to children.
- The need for reflective practice.
- That an Occupational Performance model provides legitimacy to OT practice.
- That intervention to school aged children should not be devalued.
- Best practice is about providing a holistic, integrated service.

Section A:		For Office Use
QA1 **Please indicate the classification of your organisation:**		R#
	Please tick the appropriate box: (one choice only)	
Government	☐ 1	1.1
Non – government	☐ 2	1.2
Private	☐ 3	1.3
Other, please specify _____ _____	☐ 4	1.4
QA2 **Please indicate the type of Occupational Therapy services provided by your department:**		
PLEASE SEE DEFINITIONS BELOW	**Please tick the appropriate box/es: (multiple choices available)**	
Remediation	☐ 1	2.1
Habilitation	☐ 2	2.2
Rehabilitation	☐ 3	2.3
Health Promotion	☐ 4	2.4
Preventative	☐ 5	2.5
Social Integration	☐ 6	2.6
Other, please specify _____ _____	☐ 7	2.7

Remediation: Focus is on training/retraining of skills by intensive practice. Aim is total or near total recovery of skills. For example, visual perceptual training.

Habilitation: The process of developing new skills and behaviours, eg. tie shoe lases.

Rehabilitation: The re-learning or re-development of lost skill or behaviour. Focus is on adjustment to and compensation of temporary or permanent difficulties. Aims are on achieving independence, to restore or maintain optimal functionality, to compensate for disability. This can include client education, the use of aids, appliances, orthoses and environmental adaptations.

(Definitions continues on next page)

Section A: (continues)	For Office Use
Health Promotion: Aims at enabling clients to increase control over their own health and to improve it. Focuses on client education and the influences of political, economic, social, cultural, environmental, behavioural and biological factors on health. **Preventative:** Focus is on the prevention of diseases and health related problems by means of patient education, early detection and intervention. **Social Integration:** Focus is on the facilitation of social inclusion of the client in settings, which can include schools, leisure settings and employment.	
QA3 **Please provide your organisation's mission statement or describe its mission/ overall goal:** _____ _____ _____ _____ _____ _____ _____ _____	3
QA4 **Please indicate your department's main area of practice:** **Please tick the appropriate box/es: (multiple choices available)**	
Physical impairment ☐1	4.1
Cognitive / intellectual impairment ☐2	4.2
Psychiatric impairment ☐3	4.3
Development delays and scholastic difficulties ☐4	4.4
Neurological impairment ☐5	4.5
Medical / Surgical ☐6	4.6
Medico-Legal ☐7	4.7
Other, please specify ☐8 _____ _____ _____ _____ _____ _____	4.8

Section A: (continues)		For Office Use
QA5 Please indicate which Occupational Therapy approaches / models are currently used by your department:		
PLEASE SEE DEFINITIONS BELOW	**Please tick the appropriate box/es: (multiple choices available)**	
Biomechanical Approach	☐ 1	5.1
Sensory Integration	☐ 2	5.2
Neuro-developmental Approach	☐ 3	5.3
Family centered approach	☐ 4	5.4
Cognitive-perceptual Approach	☐ 5	5.5
Behaviour modification	☐ 6	5.6
Groupwork	☐ 7	5.7
Canadian Occupational Performance Model	☐ 8	5.8
Cognitive Disability Model	☐ 9	5.9
Rehabilitative Approach	☐ 10	5.10
Activity Therapy	☐ 11	5.11
Assistive Technology	☐ 12	5.12
Client Centered Approach	☐ 13	5.13
Community Based Approach	☐ 14	5.14
Others, please specify	☐ 15	5.15
_____		
_____		
_____		

Biomechanical approach: Based on the mechanical principles of kinetics, kinematics and the geometry of motion. Focuses on the restoration of dysfunction through muscle strengthening, improved range of motion, improvement of coordination and increased endurance.

Sensory Integration: Focus is on how the brain processes sensation and organises responses. Attention is given to sensory development and organisation. Includes the approaches of King and Ayers.

Neuro-developmental approach: Based on the principles of motor control, neuromuscular facilitation and sensory integration. It has a strong developmental base. Examples: Bobath, Brunnstrom and Rood.

Section A: (continues)

For Office Use

Family centered approach: Clients are viewed within the context of their environment and the context of their families. Emphasis is on the relationships between family members and the influence of these on a client. Family members and other professionals are involved in assessment and intervention.

Cognitive-perceptual approach: Concerned with perceptual deficits. Can be either diagnostic, remedial or compensatory.

Behaviour modification: Desirable behaviour is taught or undesirable behaviour removed.

Group work: Concerns the dynamics of group interactions and processes, as well as their effects on the behaviour and reactions of group members.

Canadian Occupational Performance Model: Emphasises a holistic view of a person; the worth of individuals; role expectations; developmental age; environment and experiences. It focuses on client education and is client centered.

Cognitive Disability Model: A compensatory approach, which seeks to maximise residual function through task adaptation and environmental adaptation rather than expecting the individual to change.

Rehabilitative Approach: A compensatory approach for patients who live with a disability on a temporary or permanent basis. It focuses on the use of a person's remaining strengths to achieve the highest level of independence. This approach uses adapted techniques and equipment.

Activity Therapy: This approach is based on concepts of therapeutic community or milieu therapy and group dynamics.

Assistive Technology: Focus is on the use of different types of technology to promote functional independence. It includes augmentative communication, switches and powered mobility.

Client Centered Approach: This approach encourages the clients to direct their own therapy as far as possible; to accept personal responsibility and to be actively involved in making decisions.

Community Based Approach: Active involvement of community or key stakeholders of a project or programme; responsibility for and implementation of the programme lies with both the therapist and the community. Acceptance and sustainability of intervention and education of the community are emphasised.

QA6 Please indicate the geographical area served by your department's service:

	Please tick the appropriate box/es: (multiple choices available)	
Metropolitan (population greater than 100 000)	☐ 1	6.1
Non Metropolitan:		
Urban centres (population greater than 1000)	☐ 2	6.2
Rural areas (population of 200 to 999 people)	☐ 3	6.3
Rural areas including ***remote*** areas (low population density and geographically isolated)	☐ 4	6.4

Section A: (continues)		For Office Use
QA7 **Please indicate the approximate range in kilometres covered by your department's service:**	Please tick the appropriate box: (one choice only)	
Between 5 and 15 kilometers	☐ 1	7.1
Between 15 – 30 kilometres	☐ 2	7.2
Between 30 – 50 kilometres	☐ 3	7.3
Between 50 - 100kilometres	☐ 4	7.4
More than 100 kilometres	☐ 5	7.5
QA8 **Please indicate the number of personnel currently part of your department:**		
Occupational Therapists	1	8.1
Occupational Therapy Assistants	2	8.2
Administrative Personnel	3	8.3
Technical Instructors	4	8.4
Other, please specify	5	8.5

QA9 **Please indicate the number of Occupational Therapists at each level of seniority:**		
OT Manager (Chief Occupational Therapist/ Senior Therapist / Therapist in charge)	1	9.1
Intermediate level therapists	2	9.2
Base level / entry level therapists (less than two years' experience)	3	9.3

Section A: (continues)		For Office Use
QA10 Please indicate the number of Occupational Therapists in the following positions:		
Full time, permanent	1	10.1
Full time, temporary(contract or casual)	2	10.2
Part time, permanent	3	10.3
Part time, temporary(contract or casual)	4	10.4
Contract / hourly paid	5	10.5
QA11 Please indicate the average client – therapist ratio in your department:		
	Please tick the appropriate box: (one choice only)	
Less than 12 clients per 1 therapist	☐ 1	11.1
Between 12 and 25 clients per therapist	☐ 2	11.2
More than 25 clients per therapist	☐ 3	11.3
QA12 As Manager of Occupational Therapy services of your organisation, have you had any training to assist you in your managerial duties?		12.1
	Yes / No	
	☐ 1 ☐ 2	12.2
❶ If **yes**, go to QA13 ❶ If **no**, go to QA14+B157		

Section A: (continues)		For Office Use
QA13 If yes, please provide the 5 most recent training sessions:		
Type/topic of training:	**Length of training in days:**	
_____	……..Days $_1$	13.1
_____	……..Days $_2$	13.2
_____	……..Days $_3$	13.3
_____	……..Days $_4$	13.4
_____	……..Days $_5$	13.5
QA14 Please indicate the main venues of service delivery of your department:		
Indicate the approximate percentage of services provided at each location, e.g. Organisation's home base 70%, Clients' homes 30% and please make sure that the total percentage equals 100%.		
Organisation's home base	……..% $_1$	14.1
Organisation's satellite facilities	……..% $_2$	14.2
Clients' homes	……..% $_3$	14.3
Community facilities eg. Library, Swimming Pool	……..% $_4$	14.4
Educational facility as is appropriate to client group	……..% $_5$	14.5
Residential facility as is appropriate to client group	……..% $_6$	14.6
Other, please specify	……..% $_7$	14.7
	100%	
_____		
_____		

Section A: (continues)				For Office Use
QA15	**Please indicate whether your department currently employs any of the following strategies:**			
PLEASE SEE DEFINITIONS BELOW	**Yes**	**No**	**Unsure**	
Therapy assistants	☐ 1	☐ 2	☐ 3	15.1
Personnel substitution	☐ 1	☐ 2	☐ 3	15.2
Multi-skilling of support staff	☐ 1	☐ 2	☐ 3	15.3
Multi-skilling of therapists	☐ 1	☐ 2	☐ 4	15.4

Therapy assistants: The traditional use of therapy assistants to perform tasks that do not require the specialised skills of the Occupational Therapist, e.g. to assist in group work; for craft related instruction and assistance with administrative duties.

Personnel substitution: The use of other service providers to do the work usually done by Occupational Therapists. Examples are where cetain tasks, usually performed by an Occupational Therapist, are delegated to assistants; classroom assistants, support workers, nurse practioners.

Multi-skilling of support staff: The cross-training of support staff to perform procedures and functions in two or more disciplines. An example would be the use of a therapy assistant by both Physiotherapists and Occupational Therapists.

Multi-skilling of therapists: Cross training of a therapist to gain knowledge of other disciplines. Therapists keep other disciplines' goals in mind during intervention, but maintains own profession's boundaries.

QA16	**Does your department currently have a waiting list for Occupational Therapy services?**			
		Yes	**/ No**	
↓	If **yes**, go to QA17	☐ 1	☐ 2	16.1
↓	If **no**, go to QA18			16.2
QA17	**Does your department provide a service to these clients while they are on the waiting list, e.g. home programmes?**			
		Yes	**/ No**	
		☐ 1	☐ 2	17.1
				17.2
QA18	**What is the average waiting time for an assessment?**			
Please indicate number of **days**:		……..**days**		18
QA19	**What is the average waiting time for intervention/treatment?**			
Please indicate number of **days**:		……..**days**		19

Section A: (continues)		For Office Use
QA20 Please indicate which of the following Service Delivery Models your department employs:		
PLEASE SEE DEFINITIONS ON NEXT PAGE		
Consultation	☐1	20.1
Monitoring	☐1	20.2
Direct, 1:1	☐1	20.3
Direct, group	☐1	20.4
Multi-disciplinary	☐1	20.5
Interdisciplinary	☐1	20.6
Transdisciplinary	☐1	20.7
Case management	☐1	20.8
Other, please specify:	☐1	20.9
_____		
_____		
_____		

Consultation: A collaborative interactive process between therapist and client / other service provider. Therapist is not directly involved in the implementation of treatment principles. Therapist is still primarily responsible for the outcomes of intervention.

Monitoring: This implies the monitoring of an intervention programme, as administered by other service providers.

Direct 1:1 The use of specialised techniques and approaches with one client. Therapist as regular contact with clients.

Direct, group: The use of specialised techniques and approaches with a small group of clients. Therapist has regular contact with clients.

Multi-disciplinary: Each professional provides an initial assessment of the client. Results are interpreted according to each disciplinary perspective and problems are remediated by individual professionals. Interventions tend to occur in isolation of other disciplines. Disciplines mostly "co-exist". Other professionals may be available for consultation.

Interdisciplinary: Assessment can occur independently or in a team. Formal communication between professionals occur and a case manager may be assigned. Intervention can reflect other disciplines' input. Group decision making and some interaction between professionals occur.

(Definitions continues on next page)

Section A: (continues)	For Office Use

Transdisciplinary: Collaboration between team members occur during assessment, planning and intervention. After the initial assessment, a comprehensive individual assessment plan is drawn up and implemented by 1/2 appointed professionals. The appointed program facilitator implements the program designed by all team members. Consultation and direct assistance is provided by other team members. Crossing of disciplinary borders, professions and incorporation of these skills into one's own practice, occur.

Case management: A case manager coordinates the services provided to a client, ensures effective and efficient service delivery. Client centered; focuses on continuity of services; on makings services accessible and promotes accountability and independence.

QA21 Does your department function according to a strategic and/or business plan?

Yes	No	Unsure	
☐ 1	☐ 2	☐ 3	21.1
			21.2
			21.3

QA22 Has your department employed a strategic analysis in the past, eg a SWOT analysis?

Yes	No	Unsure	
☐ 1	☐ 2	☐ 3	22.1
			22.2
			22.3

SWOT analysis: As part of an organisation's strategic planning, a SWOT analysis is done, which includes an organisation's strengths, weaknesses, opportunities and threats.

QA23 Does your department operate according to a mission and goals?

Yes	No	Unsure	
☐ 1	☐ 2	☐ 3	23.1
			23.2
			23.3

QA24 Does your department regularly assess the effectiveness of its service delivery?

Yes / No		
If **yes**, go to QA25	☐ 1	24.1
If **no**, go to QA26	☐ 2	24.2

Section A: (continues)		For Office Use
QA25 **If yes, please indicate whether your department includes the following persons' input in assessment and development of services:**	**Yes**	
Clients/clients	☐ 1	25.1
Personnel	☐ 1	25.2
Referring agencies(e.g. schools and other services)	☐ 1	25.3

QA26 **How much time per week do you spend on the following MANAGEMENT tasks?** **Indicate the approximate percentage of time spent on each activity, e.g. Planning 70%, Organising 30% and please make sure that the total percentage equals 100% to indicate a full week.**		
PLEASE SEE DEFINITIONS BELOW		
Planning	.....% 1	26.1
Organising	.....% 2	26.2
Leading	.....% 3	26.3
Controlling	.....% 4	26.4
Human resource management	.....% 5	26.5
External Relations	.....% 6	26.6
Monitoring the environment	.....% 7	26.7
	100%	

Planning: Setting performance objectives and identifying the actions needed to accomplish them. Includes policy formation, planning objectives, setting priorities and planning strategies.

Organising: Dividing the work that needs to be done, coordinating the results to achieve a desired purpose, management of resources.

Leading: Directing the work efforts of other people to successfully accomplish their assigned tasks.

Controlling: Monitoring performance, comparing actual results to objectives and taking corrective action as necessary.

Human resource management: Personnel related tasks concerning the relationship between the organisation and its staff, includes recruitment, training, career development and promotions.

External Relations: Includes networking, public relations, contact with referring agencies and suppliers.
Monitoring the environment: Includes environment scanning and assessment.

Section A: (continues)	For Office Use
QA27 Please indicate your formal time division: **Indicate the percentage of time spent for each activity, e.g. Administration 70%, Research 30% and please make sure that the total percentage equals 100% to indicate a full week.** Tasks related to general administration: .....% 1 Tasks related to clinical work: .....% 2 Tasks related to research: .....% 3 Others, please specify: .....% 4 **100%** _____ _____ _____ _____ _____ _____ _____ _____	27.1 27.2 27.3 27.4
QA28 Please describe your departments service delivery model: _____ _____ _____ _____ _____ _____ _____ _____	28

Section B:

		For Office Use
QB1	**How would you describe your own MANAGEMENT style? Circle the number on the scale to describe the degree to which you identify with each of the following:** **1 - Strong identification with statement.** **2 - Moderate identification with statement** **3- Do not identify with statement at all.**	
Predicting problems and developing strategies to prevent the problems from occurring.	1----------2----------3	1.1
Tendency to mostly react on and address problems that have occurred.	1----------2----------3	1.2
Tendency of manager to make most decisions on management level; close supervision of personnel.	1----------2----------3	1.3
Tendency to involve personnel in decision making processes; provides more freedom to personnel	1----------2----------3	1.4
Focus on external changes and trends that influence services of the department; has a network of external contacts	1----------2----------3	1.5
Focus on internal trends and changes in the department	1----------2----------3	1.6

			For Office Use
QB2	**How important do you consider each of the following MANAGEMENT tasks Please use the scale to indicate their rank of importance:** **DEFINITIONS ON NEXT PAGE**		
	Not important at all	**Very important**	
Planning(including strategic planning	X----------	----------X	2.1
Organising	X----------	----------X	2.2
Leading	X----------	----------X	2.3
Controlling	X----------	----------X	2.4
Human Resource Management	X----------	----------X	2.5
External Relations	X----------	----------X	2.6
Monitoring the environment	X----------	----------X	2.7

Section B: (continues)	For Office Use

Planning: Setting performance objectives and identifying the actions needed to accomplish them. Includes policy formation, planning objectives, setting priorities and planning strategies.

Organising: Dividing the work that needs to be done, coordinating the results to achieve a desired purpose, management of resources.

Leading: Directing the work efforts of other people to successfully accomplish their assigned tasks.

Controlling: Monitoring performance, comparing actual results to objectives and taking corrective action as necessary.

Human resource management: Personnel related tasks concerning the relationship between the organisation and its staff, includes recruitment, training, career development and promotions.

External Relations: Includes networking, public relations, contact with referring agencies and suppliers. Monitoring the environment: Includes environment scanning and assessment.

QB3 How important do you consider each of the following to be in terms of their involvement in the assessment and development of services in general (does not need to be a reflection of current practice).

Please use the scale to indicate their rank of importance:

1- Definitely unimportant
2- Probably unimportant
3- Probably important
4- Definitely important

Please tick the appropriate box:	**1**	**2**	**3**	**4**	
Clients	☐1		☐2	☐3 ☐4	3.1
Personnel	☐1		☐2	☐3 ☐4	3.2
Referring agencies (e.g. schools and other services)	☐1		☐2	☐3 ☐4	3.3

QB4 Do you see a need for further training for yourself in management?

Yes	**No**	**Unsure**	
☐1	☐2	☐3	4.1
			4.2
			4.3

Section B: (continues)

For Office Use

QB5 **Please indicate on the scale your level of comfort in dealing with each of the following managerial tasks:**

PLEASE SEE DEFINITIONS BELOW

Please use the scale to indicate their rank of importance:

1- Not comfortable
2- Somewhat comfortable
3- Comfortable
4- Unsure

Please tick the appropriate box:	**1**	**2**	**3**	**4**	
Conflict management	☐	☐	☐	☐	5.1
Negotiating	☐	☐	☐	☐	5.2
Financial planning	☐	☐	☐	☐	5.3
Strategic planning	☐	☐	☐	☐	5.4
Facilitating change	☐	☐	☐	☐	5.5
Delegating work	☐	☐	☐	☐	5.6
Being innovative	☐	☐	☐	☐	5.7
Involvement in higher levels of management of your organisation	☐	☐	☐	☐	5.8

Conflict management: The ability to manage conflict in relationships at upper management, management and employee levels.

Negotiating: To bring about a decision by discussion and settlement of terms. Includes the ability to foresee difficulties in obtaining the ideal decision and to be able to negotiate for a desirable outcome.

Financial planning: To plan service delivery according to allocated budget.

Strategic planning: To analyse factors impacting service delivery, to be able to anticipate problems, plan appropriate strategies and alternatives.

Facilitating change: To initiate change at any level within the department.

Delegating work: To identify appropriate tasks to delegate and to entrust tasks to employees.

Being innovative: Trying out new initiatives.

Involvement in higher levels of management of your organisation: To participate in higher management levels in discussions, decision making, etc.

Section B: (continues)				For Office Use
QB6	**Do you feel that the current venue/s used by your organisation are effective and adequate for Occupational Therapy service delivery?**			
	Yes	**No**	**Unsure**	6.1
If **yes**, go to QB8	☐ 1	☐ 2	☐ 3	6.2
If **no**, go to QB7				6.3

QB7	**If No: Indicate your preference regarding changing the use of venues for your department:**			
Please tick the appropriate box:	**More**	**The Same**	**Less**	
Organisation's home base	☐ 1	☐ 2		7.1
Organisation's satellite facilities	☐ 1	☐ 2		7.2
Clients' homes	☐ 1	☐ 2		7.3
Community facilities, facilities eg. Library	☐ 1	☐ 2		7.4
Educational facility as is appropriate to client, e.g. classroom	☐ 1	☐ 2		7.5
Residential facility as is appropriate to client, e.g. Aged care facility	☐ 1	☐ 2		7.6
Other, please specify	☐ 1	☐ 2		7.7

QB8	**Please indicate whether you would consider the use of any of the following strategies in the future:**			
PLEASE SEE DEFINITIONS BELOW				
Please tick the appropriate box:	**Yes**	**No**	**Unsure**	
Personnel substitution	☐ 1	☐ 2	☐ 3	8.1
Therapy assistants	☐ 1	☐ 2	☐ 3	8.3
Multi-skilling of support staff	☐ 1	☐ 2	☐ 3	8.4
Multi-skilling of therapists	☐ 1	☐ 2	☐ 4	8.5

(Definitions continues on next page)

Section B: (continues)

For Office Use

Personnel substitution: The use of other service providers to do the work usually done by providers with with specific qualification, credentials or title. Examples are nurse practitioners; occupational therapy assistants; classroom assistants who are trained to perform certain specialised intervention techniques with clients.

Therapy assistants: The traditional use of therapy assistants to perform tasks that do not require the specialised skills of the Occupational Therapist, e.g. to assist in group work; for craft related instruction and assistance with administrative duties.

Multi-skilling of support staff: The cross-training of support staff to perform procedures and functions in two or more disciplines. An example would be the use of a therapy assistant by both Physiotherapists and Occupational Therapists.

Multi-skilling of therapists: Cross training of a therapist to gain knowledge of other disciplines. Therapists keep other disciplines' goals in mind during intervention, but maintains own profession's boundaries.

QB9 **Do you think that services to clients on your department's waiting list is adequate?**

Yes / No

☐$_1$ ☐$_2$ 9.1

Please explain: 9.2

QB10 **Do you think that the current resources available for your department's service delivery is adequate and effective?**

Yes / No

☐$_1$ ☐$_2$ 10.1

Please explain: 10.2

QB11 **Do you think that the current Service Delivery Models employed by your department are effective and adequate?**

Yes No Unsure

☐$_1$ ☐$_2$ ☐$_3$ 11.1

If **yes**, go to QB13

If **no**, go to QB12 11.2

11.3

Section B: (continues)				For Office Use
QB12 If No: Please indicate which model/s you would prefer to use more:				
PLEASE SEE DEFINITIONS BELOW	**Yes**	**No**	**Unsure**	
▪ Consultation	☐1	☐2	☐3	12.1
▪ Monitoring	☐1	☐2	☐3	12.2
▪ Direct, 1:1	☐1	☐2	☐3	12.3
▪ Direct, group	☐1	☐2	☐3	12.4
▪ Multi-disciplinary	☐1	☐2	☐3	12.5
▪ Interdisciplinary	☐1	☐2	☐3	12.6
▪ Transdisciplinary	☐1	☐2	☐3	12.7
▪ Case management	☐1	☐2	☐3	12.8
▪ Other, please specify:	☐1	☐2	☐3	12.9
_____				
_____				

Consultation: A collaborative interactive process between therapist and client / other service provider. Therapist is not directly involved in the implementation of treatment principles. Therapist is still primarily responsible for the outcomes of intervention.

Monitoring: This implies the monitoring of an intervention programme, as administered by other service providers.

Direct 1:1 The use of specialised techniques and approaches with one client. Therapist has regular contact with clients.

Direct, group: The use of specialised techniques and approaches with a small group of clients. Therapist has regular contact with clients.

Multi-disciplinary: Each professional provides an initial assessment of the client. Results are interpreted according to each disciplinary perspective and problems are remediated by individual professionals. Other professionals are available for consultation.

Interdisciplinary: After independent assessment of a client, formal communication between professionals occur and a case manager maybe assigned. Intervention generally occurs within an isolated therapy model. Group decision making and some interaction between professionals occur.

Transdisciplinary: After the initial assessment, a comprehensive individual assessment plan is drawn up and implemented by 1/2 appointed professionals. Consultation and direct assistance is provided by other team members. Crossing of disciplinary borders, professions and incorporation of these skills into one's own practice, occur.

Case management: A case manager coordinates the services provided to a client, ensures effective and efficient service delivery. Client centered; focuses on continuity of services; on making services accessible and promotes accountability and independence.

Section B: (continues)		For Office Use
QB13	**Please state any problematic issues that you perceive in your department's current service delivery:** _____ _____ _____ _____ _____	13
QB14	**Do you perceive a need for change in the Service Delivery Models of your department?**	
		Yes **No** **Unsure**
❶	If **yes**, go to QB15	☐1 ☐2 ☐3 — 14.1
❶	If **no**, END	14.2
		14.3
QB15	**If yes to QB14: How would you describe the ideal service delivery model for your department?** _____ _____ _____ _____ _____ _____ _____	15
QB16	**If yes to QB14, Do you foresee difficulty in facilitating change in your department?**	
	Yes **No** **Unsure**	16.1
	☐1 ☐2 ☐3	16.2
		16.3
QB17	**If yes to QB14, please indicate in which areas you foresee difficulties:**	
Ability for upper management to see the need for change	☐1	17.1
Ability for personnel to see the need for change	☐2	17.2
Ability to develop action to meet need	☐3	17.3
Ability to mobilise resources for action	☐4	17.4
Unsure	☐5	17.5

Section B: (continues)	For Office Use
QB18 If yes to QB14, Apart from the options provided above, please indicate the enablers and barriers that you perceive regarding facilitating change in your department: Enablers: 1 _____ _____ _____ _____ Barriers: 2 _____ _____ _____ _____	18.1 18.2
QB19 If yes to QB14, what kind of support or training would you require to facilitate change? _____ _____ _____ _____ _____ _____	19