



Université d'Ottawa - University of Ottawa

PERMISSION DE REPRODUIRE ET DE DISTRIBUER LA THÈSE

PERMISSION TO REPRODUCE AND DISTRIBUTE THE THESIS

NOM DE L'AUTEUR / NAME OF AUTHOR:	Dawn Burnett
ADRESSE POSTALE / MAILING ADDRESS:	164 Fanshaw Avenue Ottawa, Ontario K1H 6C9
GRADE / DEGREE:	ANNÉE D'OBTENTION / YEAR GRANTED
Ph. D - Education	2003
TITRE DE LA THÈSE / TITLE OF THESIS: Meeting the Needs: Rehabilitation Therapists Facing the Challenges of Inclusive Education	

L'auteur permet, par la présente, la consultation et le prêt de cette thèse en conformité avec les règlements établis par le bibliothécaire en chef de l'Université d'Ottawa. L'auteur autorise aussi l'Université d'Ottawa, ses successeurs et cessionnaires, à reproduire cet exemplaire par photographie ou photocopie pour fins de prêt ou de vente au prix coûtant aux bibliothèques ou aux chercheurs qui en feront la demande.

Les droits de publication par tout autre moyen et pour vente au public demeureront la propriété de l'auteur de la thèse sous réserve des règlements de l'Université d'Ottawa en matière de publication de thèses.

The author hereby permits the consultation and the lending of this thesis pursuant to the regulations established by the Chief Librarian of the University of Ottawa. The author also authorizes the University of Ottawa, its successors and assignees, to make reproductions of this copy by photographic means or by photocopying and to lend or sell such reproductions at cost to libraries and to scholars requesting them.

The right to publish the thesis by other means and to sell it to the public is reserved to the author, subject to the regulations of the University of Ottawa governing the publication of theses.

N.B. LE MASCULIN COMPREND ÉGALEMENT LE FÉMININ

July 29/03
DATE

Dawn Burnett
(AUTEUR) SIGNATURE (AUTHOR)



Université d'Ottawa • University of Ottawa



Université d'Ottawa • University of Ottawa

FACULTÉ DES ÉTUDES SUPÉRIEURES
ET POSTDOCTORALES

FACULTY OF GRADUATE AND
POSTDOCTORAL STUDIES

BURNETT, Dawn

AUTEUR DE LA THÈSE - AUTHOR OF THESIS

Ph. D. (Education)

GRADE - DEGREE

Education

FACULTÉ, ÉCOLE, DÉPARTEMENT - FACULTY, SCHOOL, DEPARTMENT

TITRE DE LA THÈSE - TITLE OF THE THESIS

Meeting the Needs: Rehabilitation Therapists Facing the
Challenges of Inclusive Education

J. Ahola-Sidaway

DIRECTEUR DE LA THÈSE - THESIS SUPERVISOR

EXAMINATEURS DE LA THÈSE - THESIS EXAMINERS

C. Cott

C. Duquette

A. Durieux-Smith

C. Morawski

J.-M. De Koninck, Ph.D.

LE DOYEN DE LA FACULTÉ DES ÉTUDES
SUPÉRIEURES ET POSTDOCTORALES

SIGNATURE

DEAN OF THE FACULTY OF GRADUATE
AND POSTDOCTORAL STUDIES

**MEETING THE NEEDS:
REHABILITATION THERAPISTS FACING THE CHALLENGES
OF INCLUSIVE EDUCATION**

by

Dawn Burnett

**A Thesis submitted in conformity with the requirements
for the Degree of Doctor of Philosophy
Faculty of Education
University of Ottawa**

© Copyright by Dawn Burnett (2003)



National Library
of Canada

Acquisitions and
Bibliographic Services

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale
du Canada

Acquisitions et
services bibliographiques

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-85356-X

Canada

Meeting the Needs: Rehabilitation Therapists Facing the Challenges of Inclusive Education

PhD Thesis of Dawn Burnett
Faculty of Education, University of Ottawa

Abstract

Increased popularity of the inclusive model of education where children with physical disabilities are integrated into neighbourhood schools is posing unique challenges for occupational therapists, physiotherapists, and speech-language pathologists. Researchers suggest that therapists should divest themselves of their direct treatment role and serve as consultants instructing educational personnel to apply required therapy. The purpose of this study was to examine therapists' perspectives of their working lives to identify the challenges they encounter delivering rehabilitation services to children educated in inclusive settings.

This study used a qualitative design inspired by the grounded theory approach of Strauss and Corbin (1998). Twenty therapists representing education and health care public, publicly funded private, and private sector agencies participated in semi-structured interviews which were audiotaped and transcribed. Data were analyzed using open, axial, and selective coding to determine emergent themes and develop meaningful interpretations.

This study has uncovered several issues related to therapy service delivery. Despite the claim of researchers that consultation is the method of choice in inclusive settings, according to therapists, in the present educational environment, this approach is not producing anticipated results. There is not the time, motivation, or resources to support collaboration, a necessary prerequisite for effective consultation and therapy delivery. Many children, therapists report, are "falling through the cracks." This paradigm shift to consultation has taken place despite a minimal evidence base. According to therapists, dissatisfaction with the present system is causing the rapid growth of private sector services, which further disadvantages already marginalized children and families.

This study also highlights the professional values and struggles of therapists to direct their own practice within organizational controls and resource limitations. Furthermore, it reveals that regardless of the therapy discipline, the work setting is a critical factor with regards to therapists' job contentment and satisfaction, and hence the perceived quality of service delivered. Surprisingly, instead of demonstrating discipline specific characteristics, therapists' values, rewards, and stressors are more closely aligned with the employment sector in which they work. This study has highlighted the many tensions and struggles encountered by therapists delivering therapy to children educated in inclusive schools.

ACKNOWLEDGEMENTS

This study represents the fulfillment of a lifelong goal. Although the doctoral journey is for the most part a solitary and disciplined experience, this study could not have been completed without a number of very significant members of my doctoral 'team.'

I would like to express my most sincere appreciation to my supervisor, Dr. Janice Ahola-Sidaway, for her expertise, guidance, and assistance throughout my doctoral studies. Her on-going support, especially during the final stages of the doctoral program, deserves special recognition and sincere thanks. I would also like to acknowledge the contribution of my internal committee including Dr. Andrée Durieux-Smith, Dr. Cheryll Duquette, and Dr. Cynthia Morawski. Their comments and suggestions contributed significantly to the design and final reporting of this research study. Their continued support through to the completion of the doctorate was most appreciated.

My gratitude is expressed to the 20 therapists who agreed to serve as participants in this study. Their willingness to share with me the goals, frustrations, and experiences of their practice, on top of their already very demanding work schedules, is gratefully acknowledged.

Finally, I would like to express my most sincere appreciation to Heather, Kate, and Rick (who deserves no less than an honorary doctorate for all his efforts!). Without their continued support, encouragement, and belief in my ability to see this endeavour through to the end, this life time goal could never have been accomplished.

This study was supported by a grant from the Physiotherapy Foundation of Canada.

TABLE OF CONTENTS

	Page
Chapter 1: Introduction	1
Chapter 2: Conceptual Framework Guiding the Study	5
Inclusive Education Philosophy: Meeting the Needs of All Students	7
The Inclusive Movement.....	7
The Inclusion Movement - Historical Perspective	8
Benefits, Limitations, and Controversies of Inclusion	10
Therapeutic Service Delivery Models.....	15
Professional Issues and Inter/Intra Professional Collaboration	18
Professional Autonomy and Collaborative Practice	18
Working Relationships Between Educators and Therapists	20
Therapists' Perspectives of Practice with Students in Inclusive Settings	22
Chapter Summary	26
Purpose of the Proposed Study.....	27
Research Questions	28
Chapter 3: The Research Methodology	29
Rationale for the Use of a Qualitative Approach.....	29
Participant Selection	31
Access to Participants Through Gatekeepers	34
Data Collection	37
Data Analysis	39
Trustworthiness	40
Ethical Considerations	41
Researcher's Background and Skills	42
Chapter Summary	44

Chapter 4: Findings – Participants Who They Are Where They Work.....	46
Participants – Who They Are	46
Participants – Where They Work.....	48
Therapists’ Perception of the Evolution of Therapy Service	51
Public Education Therapy Models.....	53
Public Health Care Model	54
Publicly Funded Private (School-based Therapy) Model	56
Private Therapy Models	57
Chapter Summary	61
 Chapter 5: Findings: Collaborating to Meet the Needs:	 63
Therapists’ Reception in the School Environment	64
Welcome With Mixed Messages	66
“On the Outside and On the Inside All at the Same Time”	70
The Value of Experience	71
The Importance of a Regular Schedule	72
Space – A Room of One’s Own	74
Collaborative Partnerships in the Educational Environment	76
The Principal Sets the Tone	77
Creating a Supportive Infrastructure	77
The Principal as Facilitator/Barrier	79
Collaboration with Teachers	82
Dealing with the Demands of the Inclusive Classroom	82
Teacher/Therapist Relationships	84
Collaboration with EAs	89
The EA – A Changing Profile	89
Delivery of Therapy Services by EAs	93
Collaboration with Parents	96
Burden of Care	97
Family-centered Care	99
Parental Support	101
An Attitude of Indifference	104
Chapter Summary	106

Chapter 6: Findings: Therapists' Perspectives of the Inclusion Model and the Delivery of Therapy Services.....	108
Therapists' Perceptions of Inclusion.....	109
"Integration for Integration's Sake"	109
Appropriate Space is Hard to Find	114
Equipment – A Scarce Resource	117
Therapy Services for Children Educated in Inclusive Classrooms	123
"I'm Basically a Consultant"	123
"It's More Real Traditional Therapy"	131
Therapists' Perceptions of Parents' Perspectives of Therapy.....	135
"Some of Them Sort of Fall Through the Cracks!"	138
Chapter Summary	142
Chapter 7: Findings: Issues of Professionalism	144
Professional Issues Related to Employment Context	145
A Supportive Infrastructure for Professional Practice	146
Public Sector Employees – Supported and Valued	146
School-based Therapists – You're On Your Own!	152
Private Therapists – Isolated But Not Alone!..	158
Professional Autonomy Versus Controlled Practice	161
Public Education and School-based Therapists	161
Private and Public Health Care Therapists.....	168
How We Work Together to Deliver Rehabilitation Services	172
Patterns of Disciplinary Collaboration.....	173
Collaborative Goal Setting.....	183
Barriers and Facilitators to Collaboration	186
Work Environment: It Takes Time and Effort to Collaborate	189
Communication Including the Health Record	192
Personnel/Personal Factors	196
Chapter Summary	200
Chapter 8: Discussion: Voices of the Therapists Framed in the Literature ...	203
Forging Collaborative Educational Partnerships.....	203
The Foreign School Environment Principal Sets the Tone	205
Collaboration with Teachers.....	208
Collaboration with EAs	210

Education/rehabilitation Teamwork.....	213
Collaboration with Parents.....	215
The Inclusive Experience and Therapy Service Delivery Models	220
Therapists' Views of the Impact of Inclusion.....	220
Therapy Services-Uncoordinated, Fragmented, Limited.....	224
The Treatment Dilemma – Consultation or Direct?.....	230
Professional, Interdisciplinary Issues, Barriers/Facilitators	237
Dilemmas of Professionalism	237
Collaboration Within and Among Therapy Disciplines	241
Barriers and Facilitators to Collaboration	243
Facilitators to Collaboration	244
Barriers to Collaboration	244
Synthesis	246
Chapter Summary	253
Chapter 9: Conclusion and Final Words.....	256
The Transformation of Policies to Practice.....	257
Contribution of This Study to Academic Theory	262
Trustworthiness of the Findings.....	264
Implications and Limitations of this Study.....	265
My Role as Researcher in this Study.....	269
Concluding Comments	269
Appendix A: Definition of Terms	271
Appendix B: Questions Guiding the Interview Sessions	273
Appendix C: Transcription Confidentiality Agreement	274
Appendix D: University of Ottawa REB Certificate	275
Appendix E: Letter of Invitation to Participants	276
Appendix F: Consent Form	277

Appendix G: List of Participants According to Employment Sector.....	278
References	279

CHAPTER 1: INTRODUCTION

Over the past five years, major changes to Ontario's public school system have significantly changed the educational environment for teachers, children, and parents. Educational reform has slashed school budgets with the justification that increased efficiency, standardized curricula and reporting systems, and regular province wide testing will result in overall improvement to the education system. Government spokespersons assert that these "improvements" will ensure that the needs of each child are identified and addressed (Ontario Ministry of Education, 2001).

My experience as a parent, a physiotherapist, and as a member of a working committee to design an innovative summer camp experience for adolescents with physical disabilities, caused serious reflection on the changes taking place (Burnett, Luker, & Mendelsohn, 2000). Why was an intensive therapeutic camp necessary, when presumably the therapy services required by students with special needs were provided directly in their specialized schools? Further probing of this issue with students, parents, and rehabilitation professionals revealed that children with disabilities are now, for the most part, educated in the general school system along with their peers. Although rehabilitation services including occupational therapy, speech-language pathology, and physiotherapy are provided in the regular education system, they have been reduced over the past few years such that the impact on students is becoming significant.

All public education stakeholders including teachers, students, and parents alike, have been affected by this educational reform. However, it is the children with special needs and their families who are paying an extraordinary price for these so-called "improvements." The popular press has highlighted the desperation of both teachers and parents. Albota (2001), an

elementary school teacher in this region, indicates that in her class, children with severe needs have had services greatly reduced; they receive speech-language or occupational therapy for less than an hour, once every two weeks. She goes on to add: "My greatest fear is that I will soon break.... The classroom I have described is the direct result of the Ontario government's improvements to education. I think it is important for you to know the effects of the reforms" (p. D5). Parents of children with special needs are gravely concerned about the lack of therapy services which seem to be steadily diminishing on an annual basis (Hughes, 2002; Wilcox, 2001). Wilcox, whose daughter was to be integrated into her neighbourhood school with classroom teachers expected to provide the necessary therapy, questions: "How will these teachers cope with students with even greater needs?" (p. C5). Hughes reports the desperation of a parent whose child was no longer receiving required therapy. The mother described the situation: "A speech language specialist had never even been in the classroom, and the teacher didn't know who the speech language therapist was for the school." She added, "There is also no time for one-on-one work on his fine motor skills, no time to teach him to kick or throw a ball or participate in team sports" (p. B2).

Ideally, if the system has adequate resources, the general education setting is considered by experts to be the ideal focal point for the coordination of specialized services to address the multiple and complex needs of children with disabilities (Crowson & Boyd, 1996; Lupart, 2000). This is based on the rationale that schools offer the most stable and consistent locus, apart from the family unit, from which to coordinate evaluation and treatment intervention (Smrekar & Mawhinney, 1999).

Students with complex physical and cognitive disabilities are being integrated into their neighbourhood schools in rapidly increasing numbers (Hunt & Goetz, 1997; Lupart, 2000). This

movement was triggered initially by advocates who protested traditional policies of marginalization and segregation of individuals with disabilities (Barnes, 1999). Now the momentum seems to be coming from a more pragmatic perspective. Inclusion is seen by funders and policy makers as a means of reducing costs through diminishing services and closing segregated facilities (Gow, Ward, Balla, & Snow, 1988; Ontario Ministry of Education, 2001).

For students with physical disabilities, the rehabilitation therapies, including physical therapy, occupational therapy, and speech-language pathology (See Appendix A for definition of terms) are essential services children require throughout their development to attain full academic, social, and personal potential (Giangreco, 1995; Giangreco, Edelman, & Denis, 1991). Whitworth (1994) suggests that the inclusion paradigm, together with cuts to special education funding, is requiring rehabilitation therapists to re-examine their service delivery models. Some experts propose that traditional, segregating, direct treatment models of therapy should be replaced by consultative, collaborative practices so that existing resources can meet ever increasing demands (McEwen & Shelden, 1995; Westby, Watson, & Murphy, 1994). In fact, it has even been suggested that therapists divest themselves completely from their direct role and instead serve only as consultants to teachers and educational personnel, with all therapeutic intervention fully integrated into general classroom activities (McWilliam, Young, & Harville, 1996). This train-the-trainer perspective is consistent with the philosophy of full inclusion, which argues in favour of having the teacher with educational assistants, fully responsible for meeting the diverse and specialized needs of all students within the regular classroom (Ontario Ministry of Education, 2001; Sexton, Kelley, & Aldridge, 1998).

While students, parents, and teachers consider the role of physiotherapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) essential to the

educational programming of children with special needs, these health professionals work essentially on the fringes of the educational system. Therapists face unique and difficult challenges in their efforts to address the needs of increasing numbers of children with highly complex levels of disability. Traditional practices of direct therapy intervention are frequently incompatible with present demand, resource limitations, and policies.

Surprisingly, only a small number of studies examine therapists' perspectives of their school practice and work environment (McWilliam & Sekerak, 1995; McWilliam, Young & Harville, 1996). The few existing reports reflect an American context (Case-Smith & Cable, 1995; Crowe & Kanny, 1990), prior to educational restructuring and downsizing, providing little understanding of the present work life of Canadian therapists. While some experts suggest that a consultative model of therapy delivery is preferable in integrated settings, the impact of this approach remains unexplored in Ontario classrooms. And while the literature and the popular press reveal in detail the experiences and views of educators, parents, and children with special needs, the work lives of Canadian therapists remain virtually unexplored.

The purpose of this study is to uncover the dilemmas and challenges experienced by PTs, OTs, and SLPs as they collaborate with educational personnel and each other to provide therapy services to children with disabilities who are educated in inclusive school settings. By viewing the complexities of their practice through their own eyes, this study provides essential insight into understanding the work life of rehabilitation therapists. Reflection upon actual practice in light of present challenges and limitations may foster alternate and perhaps innovative changes in therapy coordination, which will ultimately benefit the children in need of service.

CHAPTER 2: CONCEPTUAL FRAMEWORK GUIDING THE STUDY

The conceptual framework for this study is derived from the academic and professional literature related to the following three areas: the inclusion education philosophy and therapy service delivery models; professionalism and the opposing tensions of collaboration and autonomy; and therapists' perspectives of their practice with students in school settings.

The services required by children with a wide variety of physical, cognitive, and behavioural disabilities are included under the vast rubric of special education. In order to focus this research within this extensive domain, it is centered on therapists' experiences with school-aged children with physical disabilities. Physical disabilities can be seen in a broad range of conditions such as, for example, accidental head injuries, congenital birth defects, and cerebral palsy. They are characterized by "impaired control and coordination of voluntary movement" (Olney & Wright, 2000, p. 535) and may frequently be accompanied by other conditions such as seizure disorders, cognitive, auditory, visual, and speech impairments (Olney & Wright; Ratcliffe, 1998). A report by King et al. (2000a) indicated that while cerebral palsy was the most commonly reported primary problem of children with physical disabilities, few children had only one reported impairment. Over half indicated they had three or more health problems. Therefore, in keeping with the multidisciplinary, collaborative emphasis of this research, the study's focus will center on therapists' experiences with children demonstrating the variety of physical disabilities described above.

Lupart (2000), in a recent report, reveals that 15.5% of Canadian school-aged children are classified as having a disability, with approximately 15% reported to be in the moderate to severe category. Within this group, 75% of children attend their neighborhood schools, while 25%

receive their education in specialized settings. Ontario Ministry of Education (2001) statistics indicate that more than 188,000 school children in this province have specialized needs that must be addressed by the educational system. The needs of these children are varied and may be complex. In the Ottawa-Carleton region alone, the public school statistics report approximately 10,000 children with identified specialized needs (Bohuslawsky, 1999).

While the focus of this study is on rehabilitation therapists, and the challenges they face delivering service to children with physical disabilities educated in inclusive schools, the inclusive paradigm in which therapists now work has forced major changes to traditional models of therapy delivery. Therefore, in order to understand the context in which this study is based, a brief overview of the development of the inclusion movement, the proposed benefits, and the impact this has placed on therapy service delivery is warranted. This background information will help the reader understand the increasing popularity of this educational model and the pressures it places on existing and/or diminishing resources, elements which according to therapists, have a major impact on their ability to apply effective therapy.

The conceptual framework, therefore, first addresses the development of the inclusion movement and the changing models of therapy service delivery which evolved in consequence to this paradigm. The delivery of therapy services within the school system is highly dependent upon the effective, on-going collaboration between education and rehabilitation professionals (Giangreco, 1995). The second element of this framework therefore includes the issues of professional identity and the opposing tensions of autonomy and collaboration. The final component of this discussion explores therapists' perspectives of their roles and the challenges they have identified delivering service within integrated and inclusive settings. The chapter

concludes with a statement of the purpose of the study and the research questions guiding the inquiry.

The Inclusion Education Philosophy: Meeting the Needs of All Students

The Inclusive Movement

Inclusion, within the context of this study, refers to the concept of: “children with and without disabilities served [educated] in the same class, in which most of the children do not have disabilities” (Wolery & McWilliam, 1998, p. 98). This term differs philosophically from other similar concepts such as integration or mainstreaming in which children with disabilities participate to greater or lesser extents in a variety of both segregated and integrated activities with their regular classmates (Fuchs & Fuchs, 1994; Wolery & McWilliam). Inclusion is now the preferred Canadian model of education, in which children with exceptionalities are educated alongside their regular classmates, with all required accommodation and therapeutic intervention, in principle, integrated into general class activities (Lupart, 2000).

The inclusion of children with physical disabilities into their neighbourhood schools is a relatively recent phenomenon (Fuchs & Fuchs, 1994; 1998). Into the twenty-first century, popularity has steadily increased as both parents and disability advocates challenge existing policies of marginalization and segregation of individuals with disabilities (Barnes, 1999). Educational policy makers view the inclusive movement as a politically favourable strategy to produce significant savings within overextended educational budgets (Gow et al., 1988; Ontario Ministry of Education, 2001). To provide a brief overview of the inclusion movement, the educational paradigm underlying this study, the discussion will commence with a short historical perspective. This will be followed by a review of perceived benefits and limitations of inclusion, and the heated controversies which have followed its evolution. The inclusive movement has

demanding a re-examination of how therapy services can be most effectively and efficiently delivered. The section will conclude with a historical overview of therapeutic service delivery models and recommendations which have been put forth to maximize the scarce supply of rehabilitation therapy resources.

The Inclusion Movement – Historical Perspective

The inclusion movement has developed through a series of incremental stages which originated in the United States and shaped the picture of special education in Canada today (Levin & Young, 1994). Traditionally, children with severe disabilities were segregated from mainstream society, congregated in isolated settings, and withdrawn from their classrooms to receive one-on-one therapy (Brown, 1997; Giangreco, 1986). The movement to integrate children with disabilities into the mainstream took root with emergence of the normalization philosophy, attributed to the Scandinavian philosopher Nirje, and introduced to North American audiences by Wolfensberger (1972). Normalization is described as: “Utilization of means which are culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible” (Wolfensberger, 1972, p. 28). This philosophy suggests that segregating individuals with deviancies only perpetuates abnormal behaviour. Integration into normal cultural and societal contexts exposes these individuals to appropriate role models and sensitizes society to the needs and attributes of individuals with differing abilities.

The integration movement in North America was initiated by the American Public Law 94-142, proclaimed in 1975, revised in 1990 and 1997, in the Individuals with Disabilities Education Act (IDEA). This edict mandated that exceptional children had the right to an appropriate, publicly funded education, within the least restrictive environment (LRE) (Brown,

1997; Pearman, Huang, & Mellblom, 1997). With this major philosophical change, segregated settings were looked upon as discriminatory, inferior in quality, and contravening human rights and equity values (Sawyer, McLaughlin, & Winglee, 1994).

Throughout the 1980's, children with disabilities were mainstreamed into general education systems; from segregated units in regular schools into selected peer-group activities, from part-time resource rooms into regular classes, and full time into general classrooms with same-age peers (Fuchs & Fuchs, 1998). To support this transition, a special education infrastructure developed including teachers, curricula, and financial resources (Levin & Young, 1994). Promotion of the general education system for all children was spearheaded by strong advocacy groups who proposed fusion of regular and special education. This was based on the rationale that existing systems were fragmented, inefficient and discriminating, and the general system had the potential to accommodate all children (Fuchs & Fuchs, 1994; Smith & Dowdy, 1998).

The full inclusion movement, founded upon Wolfensberger's normalization philosophy, developed from these philosophical underpinnings. As the integration movement advanced into the 1990's, advocates began a more militant push for total full inclusion. They asserted: "Students with disabilities are to be viewed just as other students in the classroom; the regular classroom teacher, with the support of special educators and ancillary personnel ... are responsible for meeting all the needs of the students within the regular classroom" (Westby et al., 1994, p. 13). Full inclusion supports the merger of special and general education to meet the needs of all children, and advocates the total abolition of segregated educational programming (Fuchs & Fuchs, 1994; Sexton et al., 1998).

Benefits, Limitations, and Controversies of Inclusion

The benefits attributed to inclusion fall into the categories of psychosocial development and academic achievement (Brown, 1997; Forlin, Douglas, & Hattie, 1996). Based upon the principle of normalization, proponents of full inclusion assert that if children with disabilities are integrated with their peers, age-appropriate emotional and social behaviour will be encouraged (Giangreco, 1997). They also claim that abnormal stereotypic patterns common within segregated settings will not be reinforced (York, Vandercook, MacDonald, Heise-Neff, & Caughey, 1992). Advocates assert that normal school settings provide the opportunity for children with disabilities to acquire the essential social skills they will need as adults in mainstream society (Fuchs & Fuchs, 1998; Jenkinson, 1998). Learning in natural contexts with peers also facilitates the development of friendships and social relations, a very strong motivator for parents (Guralnick, 1994; Guralnick, Connor, & Hammond, 1995; Jenkinson, 1998). Finally, proponents of inclusion assert that on-going contact of exceptional children with student peers and adults will heighten awareness of the needs of those with disabilities, fostering increased sensitivity and respect, and ideally eventually changing societal attitudes (Nesbit, 1994; Roberts & Lindsall, 1997).

Improved academic achievement is identified as another incentive for the inclusion model. Parents and advocates state that segregated settings focus on 'soft' social and functional skills rather than academic achievement, therefore the education of children in these specialized environments is compromised (Fuchs & Fuchs, 1994). Full inclusionists feel it is the responsibility of the general education system to adapt the academic curriculum to each child. They contest the need for a standard curriculum claiming, "there is no intellectual basis for

textbook knowledge” and “the standard curriculum does not accommodate the inherent diversity ... of all students” (Fuchs & Fuchs, 1994, p. 302).

The inclusion debate is aligned with two opposing points of view. On the one side are the full inclusionists who advocate for elimination of special education, calling for the merger of general and special education systems, and melding of funds into one source (Nesbit, 1994). These proponents envisage the regular classroom meeting the needs of all children, regardless of disability, and feel it is the responsibility of general education teachers working in collaboration with special education resource personnel, to design curricular activities adapted to each individual child’s needs (Ferguson, 1997; Kaufman, 1993).

Opponents to full inclusion contest this overarching philosophy for all children with special needs, advocating that educational placements for children with disabilities should be first and foremost based upon the needs of the individual children (Smith & Dowdy, 1998). Services should be available on a continuum such that parents and teachers have a range of available choices (Fuchs & Fuchs, 1998; Smith & Dowdy, 1998; Westby et al., 1994). Many sources underline what they see as the unrealistic expectations of full inclusionists in light of diminishing financial resources to both special and general education, increasing demands on teachers with diverse normal classroom populations, and a renewed emphasis on academic standards (Chesley & Calaluca, 1997; Sexton et al., 1998; Westby et al.).

The philosophy of integration or inclusion for children with cognitive, learning and/or physical disabilities is based upon proposed benefits of improved social and emotional development, and increased emphasis on academic skills. While numerous studies exist examining the impact of inclusion on students with disabilities and their able-bodied peers, the multitude of reports do not lend themselves to easy interpretation. Variability amongst studies in

terms of special education populations, age groups, diverse pathologies, differing contexts, and interventions make it difficult to evaluate the inclusion model. Not only have studies been distinguished by the type of disability of participants (cognitive, learning and/or physical), they have also been differentiated according to the intensity of disability. This renders stringent comparison of studies and the development of consensus exceedingly difficult.

A number of reports attempt to evaluate the effects of inclusion on children with exceptionalities. Buysse and Bailey (1993) reviewed the results of 22 studies examining the impact of integration on preschoolers with a variety of physical, developmental, and cognitive disabilities. They concluded that while there is some evidence to suggest social and behavioural benefits, there was no indication that inclusion improved developmental performance outcomes in the children with exceptionalities. On the other hand, a study by Hundert, Mahoney, Mundy, and Vernon (1998) of preschoolers with severe disabilities demonstrates the contradictory findings of increased developmental gains by children in integrated versus segregated settings; however there were no perceived social benefits of one setting compared to the other. Hunt and Goetz (1997) in a review of 19 studies of inclusion of school-aged children with severe disabilities, suggest that while children with these exceptionalities demonstrate some positive social and learning outcomes in general classroom settings, the academic benefits have yet to be confirmed. Helmstetter, Curry, Brennan, and Sampson-Saul (1998) report that in their study of children with severe disabilities in segregated versus general classrooms, while the integrated setting provided more full class opportunities, the children with special needs were “less actively engaged and more passively engaged with teachers and paraprofessionals” (p.216). Learning outcomes were not evaluated. All researchers acknowledge the challenges of interpreting findings and generating conclusions in studies with small numbers of subjects with widely

disparate conditions, in a variety of experimental learning settings. Fisher, Schumaker, and Deshler (1995), in their review of the literature on the benefits of inclusion, conclude: “few validated practices exist for teachers to use” (p.17).

Studies examining the psycho-social development of children with disabilities integrated into the mainstream, reveal a variety of findings. Heiman and Margalit (1998) report that students with cognitive disabilities in special education schools document lower levels of depression and loneliness than their counterparts in self-contained classes in mainstreamed schools. Vaughn and Klinger (1998), in a review of studies related to students' perceptions of segregated versus integrated settings, found that students with learning disabilities felt specialized resource room sessions facilitated their learning, while inclusive classrooms were more conducive to making friends. Classmates of children with severe physical disabilities noted an improvement in their exceptional classmates' social skills after a period of integration in regular classes (Hunt & Goetz, 1997; York et al., 1992).

Many studies have documented increased acceptance by peers after children with disabilities have been integrated into regular classrooms (Hunt & Goetz, 1997; Rivers & Griffith, 1995). York et al. (1992) found peer interaction amongst children with severe disabilities and their peers increased after a year of integration in a middle-school general classroom, with level of pleasantness cited as an important factor for acceptance. On the other hand, Archie and Sherrill (1989) found mixed results with no conclusive evidence that contact with children with disabilities produced favourable acceptance by peers. Ferguson (1997) found overt hostility and rejection by regular students to the concept of integration of children with disabilities in their classes. This finding is supported in practice by the report of Llewellyn (1995) who found that 84% of youngsters with disabilities described bullying by their able-bodied peers, and increased

feelings of isolation and loneliness in mainstreamed classes. Other studies have confirmed similar findings (Heiman & Margalit, 1998; Law & Dunn, 1993).

Much of the literature has focused on teachers' attitudes towards integrating children with disabilities into regular classrooms on the basis that: "In order for mainstreaming/inclusion to be effective, it is generally agreed that the school personnel who will be most responsible for its success - general classroom teachers - be receptive to the principles and demands of mainstreaming/inclusion" (Scruggs & Mastropieri, 1996, p. 59). In a review of 28 studies of teachers' attitudes from 1958-1995, Scruggs and Mastropieri found that teachers supported the concept of integration, however acceptance diminished with severity of the child's disability, and the proportion of time the student spent in the regular classroom. These findings are supported by Hunt and Goetz (1997), Soodak, Podell, and Lehman (1998), and Lombard, Miller, and Hazelkorn (1998), who also report that teachers felt unprepared to address the challenges associated with full inclusion of children with severe disabilities. Teachers feel that their primary job is to teach and they resent interruptions to their academic activities (Lortie, 1975). Furthermore, teachers believe it is not their responsibility to provide on-going therapy (Scruggs & Mastropieri; Soodak et al.). All studies acknowledge the critical nature of the teacher's role and offer recommendations concerning time, training, personnel, and material resources required to facilitate successful integrated experiences.

Proponents of the full inclusion philosophy suggest social, emotional, and academic benefits, however the evidence is unclear. The opinion of researchers is guarded on the unconditional benefits of inclusion for all children with exceptionalities. In fact, several studies report that after years in inclusive classrooms, parents are choosing to transfer their children with

physical and cognitive disabilities to specialized settings in order to acquire the academic and life skills they require to be functional adults (Chesley & Calaluce, 1997; Hunt & Goetz, 1997).

In spite of numerous studies, some of which have been inconclusive on the benefits for children with exceptionalities, inclusion has become the Canadian educational model of choice for parents and policy makers (Lupart, 2000). However, there continues to exist widespread negative attitudes towards children with disabilities in the regular education system, which causes them to report feelings of rejection, loneliness, and isolation (Ferguson, 1997; Llewellyn, 1995). While teachers support the inclusion model in principle, they are apprehensive about receiving a child, especially with severe disabilities, into their general education classroom; they also feel they lack the training, time, and resources required to promote meaningful learning experiences (Scruggs & Mastropieri, 1996). Academic benefits of full inclusion on children with disabilities have yet to be confirmed (Hunt & Goetz, 1997). The words of Forlin et al. (1996) best describe the present situation: “Although there has been considerable discussion regarding the strengths and weaknesses of either full or part inclusion there has been little evidence to support or justify either position” (p. 120). While the primary focus of this study is to examine therapists’ views of their practice, an appreciation of the complex environment in which their clients are educated and into which they must adapt, will facilitate an understanding of the issues and challenges they will reveal presently. Furthermore, through the eyes of the therapists, the present study may shed further light on the inclusion experience and the impact on children with disabilities educated in these settings.

Therapeutic Service Delivery Models

Quality education of children with physical disabilities is dependent upon the availability of services provided by OTs, PTs, and SLPs (King et al., 1998; Wolery & McWilliam, 1998).

Each discipline has a specific therapeutic focus related to students with physical disabilities. OTs use daily activities and/or play to address fine movement skills as well as perceptual and learning difficulties (Wolery & McWilliam). PTs on the other hand, are concerned primarily with gross movement activities and development including walking, balance, strength, and coordination (King et al.). Communication skills including the conceptual basis and articulation of language is the primary focus of SLPs (King et al.). Therapists work individually and together to address the specific problems identified in students with exceptionalities. These services are considered essential components of programs that “allow students with handicapping conditions access to an appropriate education” (Giangreco et al., 1991, p. 16).

Bundy (1995) defines three types of therapy intervention in school-based practice. The first, consultation, assists teachers and parents to understand the child’s behavior, provides management strategies, and should ideally result in environmental changes to maximize the child’s potential within the school environment. The second, monitoring, occurs when the therapist supervises the individual(s) applying therapy to ascertain if the application is appropriate. The third, direct therapy, is utilized when the child needs specific practice to acquire a direct skill. While it is Bundy’s opinion that consultation is the preferred model, she acknowledges that considerable time and effort is required to develop the sound foundations upon which effective partnerships are based.

Within the context of the inclusive classroom, therapy can be delivered according to either a segregated or integrated model (Wolery & McWilliam, 1998). In the former traditional approach, the child is “pulled out” of the classroom to receive direct therapy, one-on-one with the therapist (Giangreco, 1986; King et al., 1998; Wolery & McWilliam). The pull-out paradigm adheres to the traditional medical model in which treatment focuses on managing the child's

disability by professionals who are considered authorities on the medical condition (Barnes, 1999; Rioux & Bach, 1994). According to Giangreco (1986, 1995) and Wolery and McWilliam, treatment goals and plans are developed autonomously by each therapist, often resulting in isolated, disconnected programming bearing little relevance to the child's educational objectives.

Rehabilitation personnel shortages and the inclusion educational model, coupled with increasing demands for service have precipitated the examination of alternate forms of service delivery (Kemmis & Dunn, 1996; Sandler, 1997; Whitworth, 1994). Although there is little empirical evidence for support, according to the scholarly and professional literature, the preferred approach, in keeping with the normalisation and least restrictive environment philosophies, integrates therapy into regular classroom activities, in close collaboration with teachers and special education personnel (Giangreco, 1995; McWilliam & Bailey, 1994; McWilliam & Sekerak, 1995; Wolery & McWilliam, 1998). The therapist serves as consultant to teachers and parents, working collaboratively to address functional, academically meaningful goals (Case-Smith & Cable, 1995; McEwen & Shelden, 1995). McWilliam et al. (1996) even suggest that therapists divest themselves of their direct therapeutic role and instruct teachers, aides, and other personnel to apply the required therapy. Within this more contemporary model, the child's disability, instead of being regarded as an illness to be cured, is considered a societal issue requiring attitudinal and environmental accommodation (Barnes, 1999; Rioux & Bach, 1994). Moreover, experts are not required to perform therapy and generalists such as elementary school teachers are viewed as being able to provide therapy for the child within a meaningful context.

Despite diminished resources and a lack of evidence espousing the benefits of integration, increasing numbers of children with physical disabilities are being educated in their

neighbourhood schools. Therapists are under heightened pressure to service larger numbers of children by training teachers in an environment where time and resources are already restrained. How are the therapists coping under these new pressures? And while the academic and professional literature advocates that direct therapy be replaced by a collaborative, consultative approach which focuses on teachers and families, is this model feasible within today's environment? This study aims to examine the nature of the dilemmas presently faced by therapists to inform both policy and practice.

Professional Issues and Inter/Intra Professional Collaboration

The scholarly and professional literature advocates a collaborative model as the preferred mode of therapy delivery in inclusive settings. The key element of the partnership is described as, "an assumption of equal power between the regular classroom teacher and the specialist, where each recognizes the experience and expertise of the other" (McWilliam et al., 1996, p. 51). While logical in principle, many factors related to professional identity and autonomy may render effective collaboration among and between similar and different professional groups problematic (Crowson & Boyd, 1996; Smrekar & Mawhinney, 1999). This discussion will begin with a review of professional autonomy and issues such as organizational culture, training, and values which impact on collaborative practice. The section will conclude with an overview of problematic issues which have arisen in working relationships between teachers and therapists.

Professional Autonomy and Collaborative Practice

While the inclusive classroom encourages partnerships between teachers and therapists to best serve the needs of children with physical disabilities, both educational and rehabilitation professionals evolve from two highly distinctive professional and organizational cultures. The

health care system continues to be largely influenced by the traditional medical model, in which physicians maintain their presence at the top of the medical hierarchy and nurses and other female dominated professions for the most part, work under their directives (Kendrick, 1995). This model embraces a curative and depersonalised approach to care in which health professionals, regardless of status, are in control and patients are considered passive recipients of their care (Barnes, 1999; Kendrick, 1995).

Socialization into traditional social norms and practices is described as being the most important component of medical entry to practice training, of even greater priority than the acquisition of professional skills and knowledge (Beattie, 1995). Beattie describes “tribal boundaries in health care” (p.11), which have evolved to solidify professional identities and maintain existing orders of power and control. The rehabilitation therapy professions, heavily female dominated, receive the majority of their entry-level education under this powerful medical model which influences individuals’ practice patterns and behaviours (McWilliam et al., 1996; Niehues, Bundy, Mattingly, & Lawlor, 1991). Bellner (1996) asserts that a positivistic medically based curriculum serves to validate the rehabilitation professions and raise their professional status in the eyes of members and the public.

As in the medical paradigm described above, the organizational culture of the educational system also serves to protect professional roles and responsibilities of members. School culture is described as being highly bureaucratic, in which stability and control are greatly valued and guarded, even at the classroom level (Gardner, 1993; Mawhinney & Smrekar, 1996; Smylie, Crowson, Chou, & Levin, 1996). Principals often believe it is their role to serve as buffers to the external environment, dispelling outside threats and setting realistic expectations by parents and community members (Smylie et al.). Principals and teachers view themselves at the top of the

school hierarchy, and consider collaborative services and their providers as add-ons rather than integral components of the system (Crowson & Boyd, 1993). Teachers have been reported to reject collaborative ventures, in part because the latter add to their already heavily burdened responsibilities (Cibulka, 1996; Smrekar & Mawhinney, 1999). In order to rebuff threats and maintain the status quo, traditional response patterns of educators have been reported to include defensiveness, procrastination, and avoidance (Smrekar, 1993; Smrekar & Mawhinney).

Both therapists and educators evolve from highly distinctive cultures each which serves to reinforce its own professional autonomy and control. True collaboration requires a major shift in the intrinsic philosophy and work practices of individuals and organizations (Cibulka, 1996; Crowson & Boyd, 1993). It is not surprising, therefore, that both overt and subversive resistance to collaboration has been reported in both education and health care settings (Cibulka; Herrington, 1996; Mawhinney, 1996; Smrekar & Mawhinney, 1999; Smylie et al., 1996).

Working Relationships Between Educators and Therapists

Professionals contemplating collaborative activities come to the partnership with deeply embedded cultures, expectations, and goals derived from their specialised disciplinary training (Kahne & Kelley, 1993; Mackay, Soothill, & Webb, 1995). Within the health care system, the concept of collaboration is in direct opposition to the intrinsic culture of autonomous and independent practitioners (Beattie, 1995). While interdisciplinary collaboration is an espoused philosophy in entry level training programs, health care students are seldom provided with structured learning opportunities to collaborate with student colleagues in other disciplines, activities which are necessary pre-requisites to effective communication in real-life practice (Mackay et al.).

When therapists enter school settings, they do so as foreigners to this environment (Niehues et al., 1991). The controlling nature of the educational milieu fosters fears of loss of professional identity and autonomy; as a result, itinerant professionals often adhere to comfortable disciplinary practices rather than risking the potential loss of autonomy that may come with collaborative activities (Crowson & Boyd, 1996). Collaborative ventures have been reported to be stalled by issues related to confidentiality of information (Gardner, 1993; Smylie et al., 1996), gatekeeping or channelling communication (Smylie et al.), and territorialism or turf protection (Crowson & Boyd).

Effective collaboration does not appear to develop spontaneously with therapists, teachers, and parents. Giangreco's view (1995) that mixed groups of educators and health professionals often work in splintered and dysfunctional fashion is supported by King et al. (1998). In this study, instead of the traditional pattern of therapists establishing goals for students on their own, parents and teachers were invited to collaborate in setting functional therapeutic objectives. An unanticipated benefit of this initiative was noted to be improved communication among participants, inferring that perhaps ongoing collaboration and goal setting was not a routine occurrence. Survey data from a variety of stakeholders affiliated with children's treatment centres indicates that integration of disciplinary interventions and service coordination require significant improvement (King et al., 2000b; McWilliam et al., 1994). Providers reported that time constraints, lack of sufficient personnel, and economic factors impeded the delivery of a collaborative approach to care (King et al.). Rivers and Griffiths (1995) uncovered separate and contradictory communication processes taking place within inclusive schools. At an administrative level, therapists and educators focused on bureaucratic activities, while meaningful communication took place only at the interpersonal, classroom level with teachers

and students. The authors offered the following conclusion: “The lack of shared experiences among adults in schools makes the successful participation of students with disabilities difficult. There is a need to look closely at how relationships among adults in schools are organized” (Rivers & Griffith, p. 293).

Although interprofessional partnerships are cited as means to improving program quality, theory and research from both education and health care suggests that effective partnerships are not easily forged. It appears that from their first initiation into their respective discipline, health care and education professionals are submerged into differing cultural rituals and values which serve to maintain and perpetuate existing orders of autonomy and control. Under conditions of stress, adherence to professional roles and boundaries is not unexpected since professional training prepares neither group for the challenges of collaboration (Edwards & Hanley, 1992). Within the traditional health care system, the training and practice of rehabilitation professionals is influenced by the medical curative model and specific gender stereotypes which are foreign to existing educational cultures. The present study, which examines therapists’ perceptions of their practice with students with special needs, will shed light on the challenges of delivering health services within a foreign educational environment and the barriers and facilitators to effective collaboration among health and educational personnel.

Therapists’ Perspectives of Their Practice with Students in Inclusive Settings

While there is strong advocacy in the literature for collaborative practice versus direct therapy in inclusive settings, data-based studies are rare (Edwards & Hanley, 1992; Giangreco et al., 1991; Kemmis & Dunn, 1996; McWilliam & Sekerak, 1995). Furthermore, Giangreco et al. claim that while therapy services in educational settings are frequently contested legal issues,

there is surprisingly little substantial evidence to support present practice patterns. The concluding segment of the conceptual framework will present an overview of studies examining therapists' perceptions of their practice. A synthesis of survey literature will be followed by a review of two existing qualitative reports.

A review of the limited number of existing studies that have focused predominantly on perceptions of rehabilitation professionals indicates that the data were mostly gathered through written questionnaires. Rainville, Cermak, and Murray (1996) surveyed 164 pediatric OTs in an attempt to understand current practice. With a 60% response rate, therapists reported using both segregated and integrated therapy delivery, with 18% of their time spent in consultation, 64% in direct treatment, and 18% allotted to travel. The majority of respondents expressed the need for more opportunities to collaborate with teachers and other therapists. A similar survey of 216 school-based OTs (response rate 67%) found that while 47% of these therapists' time was spent on direct patient care, 53% of their schedule was allotted to consultation and integrated service delivery (Case-Smith & Cable, 1995). Although these therapists expressed positive attitudes towards teacher consultation, they still highly valued the direct service delivery model. A survey of 355 school-based OTs in the northwest United States reported therapists worked predominantly in direct hands-on treatment, although they did participate in monitoring and consultative models of service delivery (Crowe & Kanny, 1990). These trends were also reported by McWilliams and Sekerak (1995) whose survey of 311 pediatric PTs demonstrated support for inclusive therapy, but a preference for the direct, pull-out model of service delivery. Factors reported to facilitate inclusive practice included smaller caseloads, attentive children, and inexperienced teachers. Finally McWilliam and Bailey (1994), compared the responses of 142 OTs, 311 PTs, and 122 SLPs on inclusive practice. They found that OTs were most supportive of

in-class therapy, followed by SLPs and PTs respectively. The authors hypothesized that this difference could be explained by the OTs' and SLPs' functional orientation to practice as compared to the PTs' specific skill focus, which favours integrated therapy only when the activity is mastered in an isolated context.

Benefits and barriers to collaboration have been noted by therapists. On the one hand, OTs and SLPs remark that collaborative practice improves efficiency, creativity, and overall quality of treatment (Edwards & Hanley, 1992). On the other hand, collaboration is reported to be hindered by personnel shortages with excessive caseloads, funding restraints, geographical and physical barriers, lack of administrative and teacher support, and inadequate preparation on the part of participants (Crowe & Kanny, 1990; Edwards & Hanley). The lack of available time to develop trust is considered a detriment to effective consultation (Case-Smith & Cable, 1995). Surprisingly, philosophical differences and personalities were not perceived as limiting factors (Edwards & Hanley), perhaps because the therapists felt these issues would be rejected as valid concerns.

One Canadian study, reported in three publications, used survey methodology to garner information about therapists' and parents' perceptions of therapy delivery (King et al. 2000a; King et al. 2000b; M. Law et al. 2001). While therapists acknowledged support for a family oriented service delivery model, providers reported that time constraints, lack of sufficient personnel, and economic factors impeded the delivery of a collaborative approach to treatment. Other studies provide a more descriptive picture of therapists' school-based practice. Lawlor and Henderson (1989) found that the majority of 118 OTs surveyed, participated as members of interdisciplinary teams. While 86% of respondents identified interventions which were unique to their discipline, 13.6% felt that none of their techniques were solely occupational therapy, and

85.6% perceived their therapeutic interventions overlapped the sphere of practice of other professionals, primarily PTs. The authors concluded that occupational therapy expertise requires further development to be fully acknowledged by other health care practitioners and educators.

In an examination of collaborative practice between OTs and teachers, Kemmis and Dunn (1996) found that collaborative goal setting had primarily an educational focus aimed at helping the child compensate for the disability, rather than attempting to rectify the impairment. While this philosophical shift in therapeutic approach proved to be effective, the authors felt that the required 60-minute meeting per week was unrealistic in present day practice. Furthermore, respondents in a survey of 255 SLPs and 344 OTs indicated that although they highly valued interdisciplinary planning, it was unrealistic to assume that meetings could take place on a monthly basis (Edwards & Hanley, 1992).

A comprehensive search of the literature turned up only two studies incorporating qualitative methodologies to explore therapy practice for students in inclusive school settings. McWilliam et al. (1996) conducted focus groups with educators, administrators, and therapists to determine practice patterns, barriers, and facilitators to inclusive services. In keeping with the above findings, therapists reported that quality service was hindered by the control of administrators, financial restraints, and personnel shortages with excessive caseloads. Expectations on the part of parents that more therapy is better, and on the part of administrators, that direct intervention is most effective, were significant limiting factors to collaborative practice. Niehues et al. (1995) conducted in-depth interviews with five expert OTs to develop an understanding of how therapy is delivered in schools. Emerging themes revealed uncertainty on the part of participants as to what defines occupational therapy practice, a perceived discomfort level within the unfamiliar educational environment, and a struggle to reconcile the dichotomy

between therapy service delivery learned within a medical model, yet delivered within an educational context.

Findings from these studies indicate that while therapists give verbal support to the concept of integrated, collaborative practice, they spend the majority of their work time in direct, hands-on treatment. It appears that factors such as time, scheduling limitations, high caseloads, professional identities and values, and traditional expectations on the part of parents and administrators prevent therapists from fully embracing this model. The need for further research in this area to examine issues related to goal setting, the consultation process, gender issues, and individual needs has been cited by many authorities (Campbell, 1987; Edwards & Hanley, 1992; Giangreco et al., 1991; Kemmis & Dunn, 1996; McWilliam & Sekerak, 1995; McWilliam et al., 1996). The information obtained from survey data, while confirming therapy practice patterns, offers little insight into the professional dilemmas and challenges faced by therapists in their everyday practice, and the ways in which issues and perspectives may differ among the rehabilitation disciplines. The statement by Niehues et al. (1991) that “little is actually known about the ways in which therapists provide services in schools” (p.196), written early in the 1990’s, still holds true at the start of the twenty-first century. The present study aims to enrich understanding of the issues facing OTs, PTs, and SLPs collectively and individually as they deliver their services to children with physical disabilities educated in inclusive school settings.

Chapter Summary

The full inclusion of children with disabilities into the regular classroom is now seen as the model of choice in Canadian education. Vast numbers of children with a wide variety of psychological, behavioural, and physical impairments are being integrated into neighbourhood

schools, due in part to parent advocacy and also on account of economic savings obtained by closing segregated facilities and reducing special education resources. Proponents of the full inclusion philosophy suggest that students with disabilities experience social, psychological, and academic benefits when they are educated with their able-bodied peers. However the empirical evidence is unclear related to these claims. Furthermore, some studies suggest that children with disabilities reported feeling isolated and shunned by their peers, and while teachers support inclusion in principle, they feel largely unprepared to accommodate children with special needs in their regular classes.

The inclusion education model requires effective collaboration between therapists and educational personnel. In an attempt to address the ever-increasing needs, a consultative model of therapy service delivery is recommended as the most appropriate and efficient means to meet the demands of all students requiring therapy. However, therapists and educators evolve from highly different cultures and value systems which reinforce their unique professional autonomy and need for control. This hinders the initiation and development of collaborative overtures. According to the literature, teachers have mixed views of inclusion and feel that their primary job is to teach and not provide therapy; therapists appear to support the consultative model in principle, however in practice, they seem to spend a large portion of their time in direct therapy. Researchers acknowledged the scarcity of rich and relevant information related to the provision of therapy services in schools.

Purpose of the Proposed Study

The professional lives of OTs, PTs, and SLPs who work with students educated in inclusive school settings is subject to the complexities of the educational environment, their

professional training and culture, the social and practical demands of the inclusive classroom, and funding sectors and policies. The purpose of this study was to examine the working lives of PTs, OTs, and SLPs in order to understand the professional and personal dilemmas they encounter and the challenges they face as they service the needs of children with physical disabilities who are educated in inclusive classrooms. An understanding of the daily struggles and tensions faced by therapists will shed light on actual practice. These findings have the potential to shape policy and action. There is little knowledge about the working lives of therapists as they try to deliver rehabilitation services in an economically restrained environment. Qualitative information will facilitate a better understanding of the challenges faced by rehabilitation therapists.

Research Questions

This study was guided by the overarching research questions: How do OTs, PTs, and SLPs describe their present practice? What are the challenges they face providing therapy services to children with physical disabilities educated in inclusive classrooms?

More specifically the study was directed by the following questions:

1. How do therapists describe the collaboration they experience delivering services to children with disabilities educated in inclusive settings? What do therapists perceive are the barriers/facilitators to collaboration?
2. How do therapists perceive the inclusion education model influences their practice?
3. What professional dilemmas do therapists encounter in their daily practice?

CHAPTER 3: THE RESEARCH METHODOLOGY

Exploring the complexity of the therapists' worklives required the development of a research strategy which not only created a directive framework to guide the inquiry, but also provided sufficient flexibility to permit each therapists' individual and unique experiences to emerge. The qualitative paradigm seemed the most appropriate design for this study. Denzin and Lincoln (2000) describe qualitative research as, "an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meaning people bring to them" (p. 3). These authors describe the qualitative researcher as a "bricoleur" (p. 4), who weaves a comprehensive image from multiple observations, reflections, and perspectives using creativity, insight, and a gradually evolving understanding.

This chapter describes the methodological framework used in this study. It presents the rationale for the use of a qualitative approach, participant selection and access through gatekeepers, data collection, and analysis. It concludes with a discussion of ethical considerations, the issue of trustworthiness, and the role and skills of the researcher in this study.

Rationale for the Use of a Qualitative Approach

This study uses a qualitative design which, according to Maxwell (1996), facilitates the researcher's appreciation of the events taking place, the meanings for participants, and the significance of the background or context in which the activities occur. Lather (1991) asserts that positivist methods "are inadequate for understanding a world of multiple causes and effects interacting in complex and non-linear ways" (p. 21). The qualitative paradigm thus seemed the

most appropriate approach to this study in order to generate the richness of data required to examine the therapists' working realities.

The study design was derived from the grounded theory approach, described by Strauss and Corbin (1998) as a process of reflecting upon and examining "social reality" (p. 4). These researchers propose that understanding real life issues can only occur through data acquired directly from individuals. The insight which evolves through the researcher's creative interpretations of the data are thus grounded or anchored in each participant's unique experiences. Charmaz (2000) adds that the strength of the grounded theory model is derived from specific techniques which guide the researcher's exploration of "empirical worlds" (p. 510). This process suggests guidelines for data analysis, which in turn directs participant selection (Creswell, 1998; Strauss & Corbin, 1990, 1998). It is an ongoing, fluid process, which demands flexibility, creativity, and sensitivity on the part of the researcher (Strauss & Corbin, 1990, 1998). The interpretations which evolve should present coherent and meaningful explanations of the data, incorporating any unanticipated inconsistencies which may emerge (Charmaz, 2000). A grounded theory approach seemed appropriate to address the research questions of this study. This process provided a structured framework for the activities of participant selection, data gathering, and analysis. It must be noted however, that the primary objective of using this approach was to develop a rich database with which to examine the therapists' perceptions of their worklives and not to develop a comprehensive, explanatory theory.

The philosophical framework for this study is derived from an interplay of the constructivist and participatory/cooperative paradigms (Lincoln & Guba, 2000). According to Guba and Lincoln (1994), the constructivist lens defines the ontological and epistemological

framework of the study; the former reflects the multiple and changing individual realities of participants, while the latter defines the critical relationship between researcher and informants. Charmaz (2000) describes constructivist grounded theory as a partnership between researcher and participant in which “the ‘discovered’ reality arises from the interactive process and its temporal, cultural, and structural contexts... The viewer then is part of what is viewed rather than separate from it” (p. 524). Lincoln and Guba (2000), in a recent work, acknowledge the contribution of Heron and Reason (1997) who incorporate the researcher/participant partnership into the “participatory/cooperative paradigm” (p. 164). The researcher is acknowledged as an essential component of the research process; his or her participation and contribution are integral to the meanings derived from the findings. The role of the researcher in this study will be discussed further on in this chapter.

Participant Selection

In the grounded theory approach, participant selection is the method used to acquire the data from which a theory of understanding emerges (Creswell, 1998), a process described as theoretical sampling (Creswell; Strauss & Corbin, 1998). Charmaz (2000) describes theoretical sampling as a procedure, which serves to develop and clarify concepts as they start to emerge from the data. The selection of participants is focused heavily on the informants’ “ability to contribute to an evolving theory” (Creswell, p. 19). Strauss and Corbin (1990, 1998) emphasize the reciprocal linkage between data gathering and analysis. Preliminary data analysis begins after the first interview and as concepts emerge, the data directs additional participant selection. They add furthermore, that the primary goal of this sampling strategy is to “maximize opportunities” (p. 202) to examine potential diversities.

At the start of data gathering, it was anticipated that therapists who service children educated in inclusive settings would, for the most part, be employed primarily by publicly funded school boards. Originally, the participant inclusion criteria included the following: therapists must be presently or recently (within the past year) working in inclusive classroom settings; they must have at least six month's experience; they must be working in collaboration with teachers and others; and their practice must include children with physical disabilities such as accidental head injuries, congenital birth defects, and cerebral palsy. Initial participants were identified through personal contacts and connections. After the first few interviews it became apparent that therapists working with children in inclusive schools were not limited only to school board employees; there was a variety of private and publicly funded agencies involved in servicing these students. The situation was much more complex than had originally been anticipated.

Upon completion of initial interviews and a cursory analysis of transcripts, it was confirmed that therapy is indeed provided to children with physical disabilities in regular classrooms by a few therapists employed by school boards. It became apparent, however, that these services were only one part of the therapy puzzle; other therapy sources also contributed significantly to the care of these children and their families. Therapy service in schools was provided, in large part, by a private agency funded through a competitive process by public monies. In addition, therapists from traditional publicly funded health institutions also played an important role in servicing these children, and while treatment was carried out within the confines of the institution, these outreach and consultative services impacted significantly upon the child in the school classroom. Another unanticipated finding was that there is a burgeoning growth of therapists in the private sector who are playing an increasingly important role in

providing therapy to students with physical disabilities. The portrait of therapy service delivery in this geographical region is thus highly complex, provided by therapists working in private and public, health and education sectors, with many therapists actually funded by a combination of both private and public sources. As the complexity of this picture emerged from the initial interview sessions, it became apparent that the employment sector had a very significant influence on the therapists' practice and experience.

In keeping, therefore, with the notion of theoretical sampling, the search for participants was directed by the objective of including representation of therapists from the diversity of agencies identified above. Throughout the study, each informant's interview was followed by preliminary data analysis. This constant "comparative method" (Creswell, 1998, p. 57) further directed participant selection and focused subsequent interviews. The overall goal was to gather information which enriched emerging themes and uncovered incongruencies and inconsistencies, a process Creswell describes as a "zigzag process" (p. 57).

Participants were recruited through several methods. At the start of the study, individuals were initially identified through personal contact with therapists known to be working in this field. These individuals were contacted directly and asked to participate in the study. The original participants suggested the names of other potential informants who were then recruited into the study. Individuals were also contacted who could identify potential participants meeting the inclusion criteria through professional and personal connections. Finally, general letters of invitation were sent out to several agencies soliciting therapists to participate in the study. Efforts were made to have an equal distribution of OTs, PTs, and SLPs from public and private health and education agencies.

Ongoing data analysis guided the sampling to the point of theoretical saturation, described by Strauss and Corbin (1998) as the point when concepts are developed and further data gathering does not reveal additional new information. A total of 20 participants were interviewed, in keeping with Creswell's (1998) recommendation that approximately 20 to 30 respondents should be sufficient to meet theoretical saturation.

Access to informants proved to be an unanticipated problem in this study. It was not initially apparent that the information I was seeking was viewed by therapists and gatekeepers as threatening and intrusive. A brief discussion of the obstacles encountered during participant recruitment is now warranted as the experiences serve to illustrate the sensitivity of the topic and the tensions surrounding this study.

Access to Participants Through Gatekeepers

Preliminary contact with therapists during the developmental phases of this study revealed an openness and willingness to share their stories, it was thus anticipated there would be no difficulty in gaining access to participants. I contacted several agency gatekeepers to obtain permission to distribute the letter of invitation to participate in the study. Agencies demonstrated markedly different responses to my solicitations. One organization reviewed and approved the proposal, and considerate of the timeframe, distributed the letter of invitation to prospective participants within a month of the initial request.

In sharp contrast are my experiences with another organization. The gatekeeper of this agency was contacted and verbal support for the project was promised. Documentation describing the study was sent and assuming all was in order, six weeks after the initial call, individuals were contacted to confirm interviews. A message from an informant informed me the

agency had subsequently instructed therapists not to participate in this project until further notice. It now became evident that this topic was one of a highly sensitive nature, and the anonymity of participants must be tightly guarded to prevent any future potential backlash on participants. A similar experience of Marshall, reported in Marshall and Rossman (1999), provided insight into this incident:

It is hard to admit when the original plan will not work. Sometimes, because the politics in a setting are so explosive, researchers must simply move on. At some point, they decide that the efforts to get around the barriers to entry are excessive, and they must respect the needs of key actors in the setting. With topics that are politicized and sensitive, the researcher should identify several potential sites so she can move to another site easily if one will not work. If one site will not work, the researcher can then move to an alternative with little delay (p. 89).

After an extended period of time (three months) and much negotiation, I finally received permission to distribute the letter of invitation. However in the end, there were very few participants from this agency. Interviews tentatively confirmed, were cancelled, and calls to potential contacts were not returned. I sensed a tension on the part of the therapists to become involved in the study and a perception that the project was not supported by this organization. At this point it was best to follow the advice of Marshall and Rossman (1999) to move on and actively seek other potential sources of participants.

Efforts to recruit therapists in other public agencies produced similar reactions to both experiences described above. One organization was highly supportive and encouraged the therapists to participate in, what they considered an important study. On the other hand, when several individuals from other agencies who initially agreed to participate in the study informed

their supervisors of the project, they were prohibited from participating. They explained to me that their administrators were uncomfortable with them taking part in research related to this highly sensitive topic. Many participants removed substantial portions of their written transcripts during the member check process, fearing personal identification on the basis of this content.

In sharp contrast to the experiences outlined above, all therapists working in the private domain overwhelmingly agreed to be interviewed. They were at ease with the project, forthcoming with their commentary and willingly discussed their frustrations with the present system.

These experiences in recruitment of informants have been recounted for several reasons. First, the resistance and concern expressed by participants and gatekeepers provides some indication of the tensions presently existing within this service delivery system and the highly political and sensitive nature of this research subject. Lee and Renzetti (1993) describe a sensitive topic as, “one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of research data” (p. 5). Similar experiences have been reported by Smrekar (1996) and Smrekar and Mahwinney (1999) where they observed defensiveness, procrastination, and avoidance as techniques to reject external threats and thus maintain the status quo within the organizational environment.

Therapists from all employment sectors, both private and public, expressed anxiety related to their anonymity in the final documentation. They were earnest in expressing their views and acknowledged the importance of this work, but they felt that if their identity was revealed, their employment could be in jeopardy. Thus throughout the discussion of the findings, efforts have been made to ensure that participants’ identities are guarded. Relevant information,

which could have perhaps influenced the richness of the data, has been eliminated. It should also be noted that the recruitment strategy and sensitivity of the topic might have influenced the selection of participants who agreed to participate in this study. It is possible that individuals discontented with the existing system and/or with specific issues to raise may have been more forthcoming to express their views. This, in turn, may have influenced the themes that emerged from the findings.

Data Collection

Semi-structured personal interviews were used to generate the data required to provide information on the challenges faced by therapists. The interviews were semi-structured to ensure that, on the one hand certain issues were addressed by all participants, while at the same time interviewees also had the freedom to expand on their experiences and elaborate on issues of concern (Marshall & Rossman, 1999). Strauss and Corbin (1998) suggest furthermore, that strict adherence to a prescribed questionnaire limits the richness and diversity of the generated data. The questions that guided the interview sessions are attached in Appendix B.

The original plan was to carry out one in-depth interview with each therapist, of approximately 60 to 90 minutes in length. However, it was not fully appreciated at the start of this study, the extent to which therapists working in today's environment are under highly pressured constraints in terms of time and accessibility. Contact with therapists to confirm an interview revealed their schedules were tightly restrained by client contact hours during the school-day schedule. Therapists were using before and after school hours and lunch periods to perform essential consulting, reporting, and ancillary activities related to their clients, and due to the hectic nature of their work day, none of them expressed the desire to meet in the evening.

Their time to participate in interview sessions within this highly charged schedule was therefore very limited. It was necessary to closely guard the interview time according to each participant's agenda, and for the most part all interview sessions were limited to the therapists' external time constraints. Interview sessions thus varied in time from 35 to 90 minutes, with the majority consisting of approximately one hour.

Recognising the therapists' time constraints and highly appreciating their willingness to participate in this study, the interview sessions were carried out at a time and place which was convenient for each participant. Interviews took place in a variety of settings including the home, an office at the university, the work place of the therapist, a coffee shop, and a restaurant. Each setting offered a degree of anonymity and privacy according to each participant's comfort level.

Throughout the interview every effort was made to put the therapists at ease, to offer probing and insightful comments, and to direct but not control the dialogue. Examination of the interview transcripts confirms that my commentary was minimal. On most occasions the interviewees were forthcoming and candid with their observations and reflections, and they seemed to welcome sharing their dilemmas and frustrations. In addition to the verbal content, participants' emotions, facial expressions, and body language were noted throughout the interview. Interviews were carried out for the most part in English. Francophone participants responded in both English and French. Their comments were transcribed and reported in the language that they used, with translation to English in italics to facilitate readers' understanding.

After each interview session, my impressions, comments, and reflections were recorded in a diary. This documentation provided a record of the methodological process and highlighted potential issues and tensions that required further investigation.

Each interview was audiotaped and transcription occurred as soon as possible after the event to facilitate recollection and interpretation. Transcribing was carried out for the most part by myself, however the assistance of a graduate student was used for several interviews including the ones carried out in French. A transcription confidentiality agreement was signed by this assistant to ascertain the anonymity of participants and the confidentiality of their data (Appendix C).

Data Analysis

Data analysis is an active, ongoing dialogue between the researcher and the data, demanding openness, creativity, and flexibility “to see beneath the obvious to discover the new” (Strauss & Corbin, 1998, p. 46). It is an iterative process that starts immediately after the first interview and culminates in “a useful conceptual rendering and ordering of the data which explains the studied phenomenon” (Charmaz, 2000, p. 511).

As discussed previously, data analysis began immediately after the first interview to direct participant selection and focus interview content. The overall approach to data analysis followed the guidelines of Strauss and Corbin (1998), beginning with open coding in which the researcher reviewed all data in minute detail, grouping individual segments into categories to form workable units for analysis. In the second stage, axial coding, categories and subcategories were linked in a rudimentary framework to create relationships between the various concepts. The final step, selective coding, involved creative assembling and refinement of the identified units and sub-units, to develop meaningful and coherent explanations and interpretations of the data. Computerized software such as Atlas or NUDIST was considered to facilitate data management and analysis. Charmaz (2000) however, cautions that computer management of data

may reduce analysis to a technical, objective process that limits the researcher's engagement with the findings. Charmaz emphasises this point citing personal communication with Lincoln (1998) who advises: "Why would you want to engage in work that connects you to the deepest part of human existence and then turn it over to a machine to 'mediate'?" (p. 520). For these reasons it was decided that manual manipulation of data would be the most expedient means to create a meaningful interpretation of the volumes of transcribed material.

In practice, each participant's interview was reviewed in detail, identifying single elements of meaning within the content, writing comments on the transcript, and registering my impressions in a self-reflective diary. Similar content units were then transferred from each transcript into a word processing file (MS Word) in order to get a holistic perspective of the individual data sub-themes. Through a process of reflection, examination, and re-examination plus discussion with colleagues and my adviser, the various elements were linked to create meaningful interpretations of the data.

Trustworthiness

Validity or trustworthiness in qualitative research is a topic of continuing controversy (Creswell, 1998; Lather, 2001; Lincoln & Guba, 2000; Maxwell, 1996). For the purposes of this study the definition of Lincoln and Guba was deemed the most appropriate. They describe trustworthiness as an affirmative response to the question, "Are these findings sufficiently authentic... that I may trust myself to act on their implications?" (p. 178). Maxwell asserts it is important that the conclusions drawn from the study are credible "within the setting or group studied" (p. 97). And while qualitative researchers make no claim that their findings are applicable to other populations, in-depth examination of specific social phenomena may

illuminate issues in similar situations and environments. Maxwell adds furthermore, that the strength of qualitative studies lies in the ability to expose the complexities of one particular situation, and these findings can then be used as a lens with which to examine other similar cases or issues.

Several strategies were used to assure the trustworthiness of the findings from this study. Triangulation or “collecting information from a diverse range of individuals and settings” (Maxwell, 1996, p. 93) was utilised by interviewing therapists from different disciplines, working in diverse settings in both private and public sector agencies. The data were subjected to member checks by having each participant review the written transcript of their interview and clarify ambiguities or omissions. The data are portrayed in “rich, thick description” (Creswell, 1998, p. 203), permitting readers to compare their own personal interpretations of the findings with that of the researcher. Underlying biases are exposed as appropriate, and inconsistencies and incongruities are incorporated into the report attempting to provide a rationale for their presence (Creswell).

Ethical Considerations

The willingness of participants to share their experiences with the researcher is a privileged opportunity, which should not be undertaken lightly. Ethical considerations in any research project should focus predominantly on the generic issues of “informed consent and protecting participants’ anonymity” (Marshall & Rossman, 1999, p. 90). Spradley (1980), in his classic document on participant observation, asserts that participants’ welfare should be of first priority, with their rights respected and the confidentiality of the information revealed assured. These underlying principles have guided this study through all phases of the research process.

This study received approval by the University of Ottawa Research Ethics Board on February 13, 2001; a copy of the certificate is attached in Appendix D. All communication and interaction with informants conformed to the policies of this review board. The letter of invitation (Appendix E) to recruit participants outlined the objectives of the study and discussed the voluntary nature of their participation in the project and an overview of issues related to confidentiality and anonymity. All participants were required to sign a consent form (Appendix F) indicating they fully understood the nature of their involvement and their right to withdraw from the study without penalty at any time. Audiotapes were transcribed by myself and an assistant who signed an agreement ensuring confidentiality of transcribed information (Appendix C).

Audiotapes were kept under lock in a secure place, and written transcriptions of the interviews were viewed only by myself and my thesis advisor. Names of agencies and locations have been removed and the privacy of individuals maintained through the use of pseudonyms. Participants reviewed their interview transcripts to ensure that they were comfortable with the material to be used in the data analysis and to verify the authenticity of the content.

Researcher's Background and Skills

In qualitative studies the researcher is, in effect, the research tool or instrument, the key element to effective data gathering; this role is therefore critical to the success or failure of the project (Marshall & Rossman, 1999). Inherent researcher bias and the impact of the investigator on participants are often cited as impacting significantly upon the scientific credibility of the research (Maxwell, 1996). Guba and Lincoln (1989) assert, however, that disclosure of the investigator's impact on the research process is an acknowledged strength of qualitative

methods. This section discusses my preparation, skills, and participation in the role of researcher in this study.

Previous graduate studies at the master's level, in addition to doctoral academic preparation, provided the background knowledge, analysis, and research skills required to undertake a study of this nature. Furthermore, professional practice as a physiotherapist in school settings and membership on many interdisciplinary teams provided an understanding of the context, a familiarity with the issues involved in collaboration, and an acknowledgement of some of the challenges confronting therapists. This common background eased the development of relationships with participants and greatly facilitated the interview process.

Participation in previous studies and projects, notably a collaborative summer camp experience for adolescents with physical disabilities, provided the interview, observation, and listening skills required for this research. My professional experience also facilitated the recruitment of participants and the development of credibility and trust essential in the participant/researcher relationship. Finally, as participants were women, I also perceived that the "nonhierarchical woman-to-woman link" described by Edwards (1993, p. 93) as facilitating open communication in feminist methodologies, also contributed to the trust established during the interviews.

Edwards (1993) asserts furthermore, that as the researcher plays a fundamental role in the qualitative research process, it is therefore imperative that, "her own feelings and experience should be analyzed as an integral part of it [the research]" (p. 184). She suggests that this insight, combined with the views of informants, will provide enriched understanding of the issues being investigated. She adds, "The researcher is a 'variable' in the interview process... Researchers bring their own life experiences to their research, and they structure what the research is about

(p. 185).” In light of these words, my perception of my role as the researcher in this study will now be examined.

At the start of the interview sessions, I attempted to maintain the distance from participants, which I felt, was appropriate for my role as investigator. During the interview process however, I found that as I listened to the therapists’ stories, I unintentionally at times, became involved in the dialogue. I became an active participant in the interview, sensing the passion of therapists and identifying with the issues they raised. Their emotions of frustration and powerlessness evoked my empathy, and I sensed their fear of retribution and ostracism if their participation in this study was uncovered. It was difficult for me to truly ‘bracket’ my experiences, and this undoubtedly has influenced the information shared by participants, the analysis of findings, and the development of topics and themes. On the other hand, my unique perspective and experience appeared to facilitate the interview process and add richness and insight to the findings that emerged.

Chapter Summary

In summary, this chapter describes the research methodology upon which this study is based. It discusses first, the rationale for the use of a qualitative approach, and outlines participant selection including access through gatekeepers, data collection, analysis, and trustworthiness. During the recruitment of participants and the interview sessions, it became apparent that this topic was one of a sensitive and highly charged nature. This chapter concludes with discussion of the ethical issues raised and addressed in this study, and an appraisal of my role as researcher and how this potentially impacted on data analysis and findings. The following

section of this dissertation is subdivided into four chapters, which present the findings and themes that emerged from this research.

CHAPTER 4: FINDINGS - PARTICIPANTS WHO THEY ARE AND WHERE THEY WORK

During the recruitment of participants and the interview sessions it became increasingly apparent that informants' responses and experiences were shaped predominantly by the nature of their employment agency. An appreciation of the work context and funding sector of participants is key to understanding the themes and insights which emerged. This introductory section to the findings of this study provides an overview of participants, a description of the various agencies which the therapists represent, and a historical overview of the evolution of the present therapy service delivery system to its present state. These elements provide the essential background framework upon which the subsequent three findings chapters are based.

Participants – Who They Are

Throughout the data gathering and analysis, it was a struggle to determine how to clearly, yet discretely, best represent participants in the research findings. On the one hand, it was evident that withholding information could compromise the richness and comprehensiveness of the content. On the other hand, the failure to maintain informants' anonymity could have similar consequences to that reported by Mizell et al. (1999), who revealed that their failure to maintain the confidentiality of participants, severely tarnished their reputation as researchers and subsequently prevented them from accessing participants for future study.

Adler and Adler (1993) define ethical issues of "self-censorship" in qualitative studies as, "the practice of omitting selected facts and features of one's research findings" (p. 250). They outline several factors that motivate researchers to exclude relevant information from reports, two of which are relevant to this study. The first they describe as the "development of

loyalties” (p. 254) which occurs when the researcher deliberately withholds information in order not to betray the trust and identity of the participants who willingly shared their stories and thus collaborated with the research. The second factor, entitled, “ongoing involvement in the research site” (p. 256) is that previously identified by Mizell et al. (1999), which occurs when the researcher may wish to maintain contact with research participants and hence does not want to hinder future relationships.

In this study both these factors came into play. While many therapists were ill at ease concerning potential repercussions from involvement in this study, they willingly shared their stories to further my research objective. Furthermore, given the very small community of therapists in the study region, it was imperative first that their identity be highly guarded, and second that opportunities for future research be maintained. Based on this rationale, the portrait of the therapists in this study will be given as group data only. Pseudonyms will be used throughout the findings and any identifying features such as individuals’ employment agency, discipline, specific program name, and speciality areas of expertise will be omitted. Agency names and identifying characteristics will also be withheld, even at the risk, in places, of compromising richness and clarity in the data.

Twenty therapists participated in this study including six occupational therapists, eight physiotherapists and six speech-language pathologists. The therapists represented a wide range of experience levels with four having worked under ten years, five over 20 years, and the majority of 11, having been in their respective professions between ten and 20 years. For the most part, the sample of therapists interviewed had worked exclusively in pediatrics. The majority of participants were English speaking, however there was a small representation of

Francophone therapists. As indicated earlier, the findings are presented in the language(s) used during the interviews.

Participants - Where They Work

The environmental context in which the therapists were employed is highly complex and fragmented. It became readily apparent during the recruitment and initial interviews that the therapists' employment situation played an important role in shaping the views and experiences of their practice. As this element is key to an understanding of the resultant findings, the work sectors and agencies represented by the therapists will now be clarified.

Participants worked in a variety of public, private, and combined public/private organizations. The agencies represented fall into four major categories, which include: public education, public health, publicly funded private, and private. Each will now be discussed in more depth.

Therapy services administered by therapists in this study were funded by traditional publicly funded organizations. Four therapists were employed by public education boards, funded by the Ontario Ministry of Education. While these participants were considered board employees, as will be revealed in a future section, they perceived they operated on the fringes of the educational environment. It was their responsibility to provide assessments for students in their respective disciplines, and to offer therapeutic programming through consultation to educational personnel and parents. The number of therapists employed by schools boards, as will be seen presently, has greatly diminished over the past years.

Six therapists worked in public health care agencies funded by the Ontario Ministry of Health. While these therapists serviced students primarily from their health care setting, they also

provided consultative outreach to teachers and educational assistants in schools. It was the responsibility of health care therapists to provide specialized assessments in the area of their disciplinary expertise. And while several provided therapeutic interventions for very limited time periods, the majority served primarily as specialized consultants to parents and educational personnel.

Four therapists were employed by a private agency that received public funds from the Ontario Ministry of Health, through a competitive process to offer therapy services to students in schools. These individuals were considered independent contractors, in that they billed the organization for the services they administered, they received no employee benefits, and they were thus responsible for paying their own taxes and other employment related financial obligations. These therapists were responsible for providing disciplinary assessments and treatment in the form of consultation to educational personnel and parents. For the purposes of this report, these publicly funded, private agency therapists will be referred to as school-based therapists.

Six therapists had previously worked in the settings just described, but had decided to entertain private practice for a number of reasons to be presented. These participants worked either as independent practitioners or in small groups with other therapists of the same or mixed therapy disciplines. These therapists were also independent contractors, billing funders directly and being responsible for their making own tax and benefit payments. These therapists were remunerated predominantly from insurance companies and directly from the pockets of parents who requisitioned their services. Many of the therapists now working in the private sector had, previously in their career, worked in several of the public and public/private agencies just

described. Their reflections provided valuable comparison of one employment setting to the other.

In order to provide clarity and continuity to the participants' comments in the coming chapters, they are listed below, in Table 1, according to pseudonym and employment sector. Each participant's rehabilitation discipline has been omitted to guard anonymity. This table has also been included in Appendix G to facilitate clarity through the findings sections.

Table 1. List of Participants According to Employment Sector

Name	Employment Sector
Cynthia	Public education
Julie	Public education
Marie	Public education
Sally	Public education
Ashley	Public health care
Caroline	Public health care
Heather	Public health care
Kate	Public health care
Margot	Public health care
Pam	Public health care
Angie	Public funded private (School-based therapist)
Emma	Public funded private (School-based therapist)
Holly	Public funded private (School-based therapist)
Jesse	Public funded private (School-based therapist)
Annie	Private
Carol	Private
Catherine	Private
Erin	Private
Lesley	Private
Nicole	Private

In order to provide further clarity and richness to the employment context, an overview, based in large part on therapists' insights of the evolution of this therapy service delivery system

will now be presented. This will be followed by the therapists' own descriptions of the settings in which they work.

Therapists' Perception of the Evolution of the Present Patchwork Model of Therapy Service Delivery

The evolution of the present system of therapy service delivery took place over approximately, a 20-year period. The therapists' comments are used to trace the development of the present system. As well as recounting changing models of service delivery, their reflections also reveal the struggles and tensions which have accompanied this transition.

Traditionally within Ontario, therapy services including OT, PT, and SLP, were provided to children with physical disabilities either in pediatric health care settings or segregated school environments. Within this model, there existed a very clear distinction between the funding for rehabilitation services from Ministry of Health sources (the former) and the Ministry of Education (the latter). School-aged children with physical disabilities were treated primarily in the educational setting by therapists who were employees of the health care organization. There was a close liaison with therapists employed by school boards who worked predominantly in segregated units. With therapy centered in primarily two settings and the health care agency providing the majority of services, collaboration and follow-through from one setting to the other was fairly seamless and consistent.

The normalization movement and Canadian human rights codes have been instrumental in creating the legislation which assures the right of all Canadian children to an appropriate education within the public system (Levin, 1994). In a recent communication, the Ontario Ministry of Education (2001) describes its objective for special education services as follows:

Providing quality special education is an important part of our quality education agenda.... The goals are to provide the best quality public education system for Ontario's children and ensure that the education system equips them for lifelong learning in a rapidly changing and competitive world (p. 1).

The traditional picture of therapy service just described, began to change in the mid 1980's when, according to Pam, the following changes took place:

Locally, the school health program [school health program refers to the therapy services delivered in schools] started in 1984. It was the bill that integrated children into the school setting; it would provide therapy services to allow them to participate in the school. Its original mandate was never to replace other therapy services. It was to be a service that meant they didn't miss time from school; they could be integrated with other children. It was at a time when they really [hadn't been integrated with other children] ... And so children on school health, really received [all of] their services only at school.

Pam goes on to clarify that therapy services for children in community schools were originally coordinated in traditional health care institutions with the objective: "to treat children within the school setting." In the early 1990's budgets to health care institutions were progressively cut. The provision of therapy services to schools was consuming substantial portions of health organizations' budgets. Throughout the 1990's school boards were also paring their finances in order to address substantial Ministry of Education reductions. A major re-organization of therapy service delivery was initiated in 1996 to produce, what was felt to be, a more cost-effective model. Pam continues: "The government mandated that all Community Care Access Centres (CCACs) would have an RFP (request for proposal), they would become a broker agency and go to tender for who would be delivering school health [school OT, PT and

SLP] services.” From that time on, the delivery of school therapy services became a competitive process.

A private company acquired a contract for school therapy services. Pam explains, “School health [therapy] really was meant for the school, it was never to replace everything that the child received. And over the time resources have tightened up, and very often that is all they receive.” Therapy services in this region are now delivered predominantly through four employment sectors, namely, public education, public health care, publicly funded/private, and private. The therapists’ words now describe in more detail the features of the work environment in which they practice.

Public Education Therapy Models

Traditional sites of therapy service delivery, focused in educational settings and health care institutions continue to exist in the present system, in a highly modified and reduced form. Therapists continue to be hired by school boards, however over the years the number of positions has been significantly reduced and the therapy mandates altered. Cynthia describes the changes she has observed in her school setting:

The school board used to hire physiotherapists. This school used to have two physiotherapists, and two physiotherapy assistants, and kids were seen everyday... then they reduced it to one full-time [physiotherapist] with two assistants. Then it went to one full-time physio with one assistant full-time, and now it’s down to two day physio with one full-time assistant.

According to Cynthia, the pay scale for therapists employed by educational agencies is largely inferior to that of therapists in other public and private sector facilities. The critical dearth

of therapy services is compounded by a large turnover of therapists and long-term vacancies in these positions. Cynthia is extremely frustrated providing inferior service, for very low wages. “It’s something I know I’m really good at and I enjoy doing it, just the pay is terrible!” she exclaims. “If I wouldn’t need the money, I mean I’d even volunteer just to do it, I would happily do it full time, but it’s really a question of logistics.”

Therapists felt that they were highly insignificant within the context of the huge educational environment. Sally explains: “Because we’re sort of an adjunct, we’re always at the end of all decision making. Because we were always the smallest group, we were always the last one for budget, for collective agreement, for pay equity, for everything, so whatever was left, that’s all we would get.” She adds, “You may be the smallest group, but you are important and you have to remind yourself that you too are significant in education.”

Since the initial interviews the number of therapy school positions have been cut further. Cynthia has resigned from her position in the school setting and several schools in this region with segregated units for children with severe disabilities have been without therapists for almost a year.

Public Health Care Model

In addition to therapists employed by public funding through the school system, there continues to be a variety of selected and specialized services offered through traditional publicly funded health agencies. This model too has undergone major transition with the evolution of the school-based therapy model. Caroline explains that her practice consists of short periods of intensive therapy to address localized problems. She describes this very specific and limited

therapy intervention as follows: “I’m going to take [the student client] for a set of 12 weeks... we’re going to work on your muscles... and see what happens if we’re making a big difference.”

Margot’s work in a health agency is with pre-schoolers prior to integration into community school settings, while both Heather and Kate provide highly specialized consultative services, serving as resources to both the local community and outlying regions. Kate explains, “I don’t provide any treatment at all actually, it is really very specific consultation.” Heather’s position is similar, “I work as a consultant to children... in that role I see them [clients] primarily for assessment but make recommendations for equipment, strategies... I don’t do the direct treatment.”

Pam claims that many parents are highly dissatisfied with present models of school-based therapy and have requested that their children continue to be followed through her health agency. “I can give you six or seven examples of clients that wanted to remain here as clients instead of going to school health and we said no,” she explains. “Why did we say no? We have (a small number) therapists that work here... Are they getting enough in the schools, no. Do you feel with our present staffing we’d be able to do it, no.” Thus even though parents would prefer that their school-aged children be seen in the health institution for regular therapy, restricted personnel and resources, coupled with a change in mandate limit the on-going programming that this service can provide.

Funding restrictions and diminished human resources now limit the capacity of traditional agencies to provide comprehensive therapy services. Instead of providing funds to health organizations to provide therapy service in school, the Ministry of Health, through the vehicle of Community Care Access Centres is using a competitive process to award school health (therapy) contracts. Interested agencies submit requests for proposal (RFPs) which are

assessed and the contract is awarded to the organization, that in the Ministry's opinion can offer the most effective programming in the most cost-efficient way. The publicly funded, private therapy model of service delivery evolved in this manner, and plays a major role in therapy programming for children in schools.

Publicly Funded Private (School-based Therapy) Model

The publicly funded/private model is the primary source of publicly funded therapy service for children with disabilities in the general school system. The school-based therapy service is funded through public monies, but is delivered by a privately run agency. Therapists, who function as independent contractors, are remunerated directly for the clients they see and the intervention they provide. There are tight constraints as to the quantity and nature of the services they are compensated for. The funding system, in effect, seems to drive the therapy services provided. Annie describes working as a therapist within the publicly funded/private model:

It's publicly funded through funding that is awarded to school care therapy [which] then hires independent contractors to deliver the services in the schools. The services were set up where you were assigned to certain children... trying to assure needs were met... still respecting funding limitations.

Jesse describes the complexity and mandate of her role as an independent contractor:

"I'm an independent contractor so in some ways... I can do what I want to do within the rule set that I have to play... It's a consultant model, that is our mandate, only to provide consultation." This mandate Jesse explains, comes from the Community Care Access Centre, the direct public funder, which in turn is dictated by the Ministry of Health. Over the years, public funds for

school therapy contracts have diminished, and this has had a direct impact on service delivery.

Emma describes how, in her view, the model has evolved to its present status:

My agency has changed a lot. I'm self-employed and I've got a contract with them, that's how it works. When I first started, we were very small... As the years have gone by they [the agency] got bigger and bigger, they got more contracts ... Lot of staff We used to be very client focused. I'm not saying that we're not client focused but our decisions were always based on our clients and now I find that decisions are based on money.

Decreased funding has translated into markedly reduced therapy services available for children in schools. "I just think services have pulled back more and more," adds Lesley. "I find they're making cutbacks and making therapy requirements stricter to the point that very few [children] get much real therapy. I see people being forced to seek out private therapy." Lesley's perception that parents are seeking additional sources of therapy for their children, was further confirmed by therapists working in all sectors of the employment environment. Thus the transition to the publicly funded/private school-based therapy model, coupled with the limited mandate and resources available in public sector health and education agencies, has precipitated the emergence of a fast developing private sector source of therapy delivery to fill in the substantial gaps.

Private Therapy Models

All therapy disciplines are represented in the private sector. Therapists work individually as independent practitioners, or with other therapists of the same or mixed disciplines as associates or independent consultants. The expansion of this sector is due, in large part, to parental discontent and frustration with the existing models of therapy service delivery just

described. Annie explains, "I've been hired privately to go in ... because the services are no longer available through the agency that funded this service." As Lesley stated earlier, "I find they're making cutbacks and making therapy requirements stricter to the point that very few [children] get much real therapy." It is Catherine's opinion that there is a specific group of parents who seek private service for their child. "You know, they're just not satisfied with this [the status quo]." She adds, "They just think, there's got to be more, or if I can't get what I want, how am I going to get it? They're not willing to sort of say that's it!" Erin suggests that even parents whose children are receiving school-based therapy are dissatisfied with this service. She explains, "Part of the problem is a lot of the parents are concerned because there is not a lot of progress to the visits as part of the school care program."

Private therapy service delivery implies the availability of funds from sources outside the public sector. Therapists were remunerated through a variety of mechanisms. Both Lesley and Annie stated they were subsidized by private insurance and parent funds. Erin claimed that for the most part she was paid directly by parents, but she felt uncomfortable at times with this system of remuneration. She explains, "If it's going to take me two hours of phone calls to figure out or to set up an inservice... I charge the parents \$___ and that's really not quite [right] ... part of it is I don't think they should have to pay for my services, I think it should be covered."

While both PT and SLP services were covered by private insurance available largely through parents' employers, occupational therapy as a rule is not within the mandate of insurance coverage. An OT explains:

Major employers like -----, the government ... they cover massage therapists, acupuncturists! It doesn't cover OT! So as an OT, there is a lot of frustration around the

organizations that have abdicated this service in their policies... This is all out of the parents' pockets!

Several therapists working privately are subsidized in large part by no fault automobile insurance, when a motor vehicle accident is responsible for the child's disability. Erin outlines the features of this coverage:

Under Bill 59 which is the auto insurance legislation, we are required, following an assessment, to provide a treatment plan. And it's a standard form that identifies your credibility, your college affiliation, your very measurable short term and long term goals with quantitative and qualitative outcomes, and you have to be able to provide an estimation of time and costs.... So that's the functioning of it. I would say that there certainly are [clients] files where the plans are questioned, particularly if it's not a recent injury, and we're still identifying some needs, but over the three and a half year period, I'm hard pressed thinking of a file where the client was not given fair treatment.

The coverage that is provided by no fault automobile insurance is so comprehensive that Catherine feels it puts other sources of funding at a disadvantage. She expresses her opinion:

You know if you're going to get hurt, if you're going to suffer any kind of a neurological incident in Canada, I'd run in front of a car afterwards. Because you know, I mean, the difference between the treatment of people who have had motor vehicle accidents and the people that had strokes or cerebral palsy or something else is very, it's night and day, because of the funding, absolutely! The other people are clawing to get services and there's no question that people who have been in car accidents [are well funded], it's true.

Private therapy services are limited to very few students. For small numbers who have suffered their disability on account of a car accident, provincial legislation mandates insurance

companies to fund 'no fault' coverage to fund required therapy. The majority of private sector funding comes from insurance provided by parents' employers or directly from the parents themselves. It is clearly evident that private therapy coverage is limited to a privileged few who have additional insurance coverage or who can afford to pay the significant costs.

The pattern of therapy service delivery in this region has changed substantially over the past twenty years. Therapy was provided predominantly by therapists employed in health care agencies who treated children with disabilities either in the school or health care environment. While a small number of therapists were also employed by school boards, the consistency of therapists from only two sources facilitated communication and collaboration. Children may have been treated at various times in both health care and school environments, however due to the consistency of personnel, the child's therapy management was relatively 'seamless' from one setting to the other.

According to therapists, throughout the intervening twenty years, health and education budgets have been cut significantly paring the personnel and the services they can offer. In an effort to provide school therapy on a more cost-effective basis, the Ministry of Health instituted a competitive process for funding these services which was awarded to a private agency. Funds to this organization have also been reduced over the past six years. What presently exists is a multi-sectored system, which operates primarily in silos. Due to elements, which will be presently discussed, communication and coordination are now the exception rather than the rule. Therapists tend to work primarily in isolation which has an important impact on the children they serve.

Chapter Summary

This chapter has provided a brief overview of the sample of therapists who participated in this study and the employment sectors in which they worked. Twenty therapists took part in this research including, six OTs, eight PTs, and six SLPs. They represented public education, public health care, publicly funded private, and private sectors. Initially, therapy services to children with disabilities were primarily provided by therapists in health care agencies. Over the past twenty years this model has changed and now therapy is provided by a variety of agencies, with therapists working in isolation under financial pressures. The therapists described briefly the characteristics of the organizational sectors in which they were employed.

Due primarily to continuous budget cuts to health and education public sectors, therapy services have been splintered from a single model of medically based service delivery to a patchwork, piecemeal system. The present model is characterized by therapists as being competitive, fragmented, two-tiered, and gravely lacking in resources. Given the complexity of the present therapy delivery system and the marked differences in employment characteristics of the various funding sectors, it is therefore not surprising that the therapists' perspectives and experiences seem to be largely shaped by their practice environment. This chapter sets the essential background framework for the study findings which will be presented in the following three chapters.

With the underlying background information described above providing the situational context for the study, the next three chapters, in effect the results of this study, provide a synthesis of participants' stories. An analysis of transcripts revealed that the issues consistently identified by therapists as reflective of their practice fell into three major themes, namely therapists' perspectives of collaboration, their impressions of the inclusion experience and

therapy service delivery, and professional issues including barriers and facilitators to collaboration. The following chapters are organized according to these three emergent themes. They attempt to provide the reader with a picture of the everyday work life of therapists caught within mazes of policies, funding sectors, professional cultures, and personal dilemmas in trying to deliver therapy services. These discussions do not attempt to offer judgement, or to evaluate programs, personal beliefs, or therapy practices. Indeed, the main objective is to examine the realities of the therapists' working lives as seen from their own unique perspective, and this, in turn, may also shed light on the situation of others such as students, teachers, and parents within the same environment.

It must be noted that all the issues to be discussed in the following three chapters are derived from the therapists' words, as seen through their own eyes and personal frame of reference. The participants' stories, framed by my interpretation and analysis as researcher, provide the framework for the discussion which now follows.

CHAPTER 5: FINDINGS: COLLABORATING TO MEET THE NEEDS

Using the guidelines for data analysis established by Strauss and Corbin (1998), each transcript was reviewed in-depth for single units of meaning, which were then grouped into larger subcategories and categories to create relationships among and between the concepts. The final step in the data analysis involved creative assembling and refinement of the various data units to develop a meaningful and coherent synthesis of the therapists' interviews. An in-depth and rigorous analysis of the transcripts in this fashion revealed three major overarching themes emerging from the data. These include issues related to collaboration, the inclusive education model, and professionalism. The following three chapters present a synthesis of the findings as revealed by the therapists according to these three themes.

This chapter addresses the first research question, "How do therapists describe the collaboration they experience delivering services to children with disabilities educated in inclusive settings?" During the interview sessions all therapists acknowledged the essential importance of collaborating with others to meet the diverse and complex needs of the children they serviced. While in principle they supported the philosophy of collaboration, in practice the therapists revealed a very different reality in the school settings. Although they were in contact with numerous individuals including teachers, parents, and educational assistants during their daily practice, a partnership approach to goal setting and programming was an uncommon experience. In fact, many times their efforts to foster collaborative relationships were fraught with obstacles and barriers well beyond their control.

The content of this chapter reveals, in the therapists' own words, the challenges and achievements they faced attempting to forge effective partnerships to address their therapeutic

goals and service their student clients. The therapists were overwhelmingly in agreement that the atmosphere they first encountered in the school was an important predictor of the nature of collaboration they would most probably experience and the degree of compliance or resistance they would receive from educational personnel. The first section of this chapter will therefore present the therapists' perspective of the initial reception they received in the schools they visited. This is then followed by an elaboration in some depth, of the various partnership experiences with essential collaborators, namely principals, teachers, educational assistants (EAs) (See Appendix A for definition and role description), and parents. Through the therapists' own words, this chapter will attempt to highlight the obstacles and facilitators they encountered in attempting to develop effective collaborative relationships.

Therapists' Reception in the School Environment

Therapists delivering their services in inclusive settings came into contact throughout their working schedule with a large number of schools each demonstrating their own unique "personality." The characteristics of each school in terms of location, size, personnel, and diversity of student population was a major contributor to the school personality and in turn influenced the reception received by the school therapists.

Nicole serviced a number of rural schools as well as urban institutions. The openness and flexibility she experienced in the former, she attributed to the relative homogeneity, stability, and smaller size of rural facilities. In contrast, the increased complexity of urban schools in terms of student numbers and diversity rendered her overtures to collaboration much more challenging. She explains: "I find that in very large schools, large numbers, is more of a problem they're [the student] one person in a group of many.... I do find that the visibility and the appreciation of

what I can bring in, tends to be a little bit better in smaller schools, where there is maybe a better resource support system.” She adds, “I find in the rural areas, a little bit more opportunity for acceptance, a little bit more opportunity for accommodation.” It was Nicole’s impression that the smaller size of rural schools and the openness of personnel facilitated working relationships with educational personnel.

Angie attempted to explain the complexity of working in schools as compared to the more traditional office setting of rehabilitation therapists:

There are challenges. You’re working with all kinds of people, if you were working in a clinic, you’d meet the child and you’d meet the parents and that’s what your interventions would be geared towards. In the school, you’re dealing with the teacher, the EA, sometimes more than one, some kids have one person in the morning one person in the afternoon Then there’s the vice-principal or the resource teacher overseeing the program, and then some how you have to communicate with the parents even though the parent is often not there.

The number of individuals the therapists encountered, the degree of commitment to exceptional students, and the existant or nonexistant channels of communication created a complex work environment that was typical of the daily practice of therapists working in schools. Therapists were exposed to a wide variety of responses to their overtures to collaboration and recommendations for intervention. Their stories reveal several predominant themes related to their reception within the school environment. First they describe an overarching school atmosphere which established communication patterns and set the tone for the success or failure of future collaborative interactions. Second, the therapists perceived that they were always considered guests within the foreign educational environment, regardless of the

frequency of their visits and the length of time they had spent in a particular school. Finally, the allocation of space to carry out the therapeutic intervention seemed consistently to be a contentious issue which symbolized to the therapists the extent to which they were considered (or not) an integral unit of the educational team. Many therapists remarked that they could sense the relationship they would have with their school immediately upon their first entry into the building. This atmosphere set the tone in many cases for the duration of the partnership. The following discussion reveals the therapists' perceptions of their reception and subsequent acceptance in the school setting.

Welcome With Mixed Messages

Itinerant therapists travelling from school to school explained that the reception they received from school personnel varied from a response of openness and appreciation of their interventions to subtle or overt rejection, with each school having its own particular personality or tone. Annie's commentary is generally characteristic of the therapists' responses. She states: "I would have to say, [the reception I received was] probably in-between the two [rejection versus open reception], I would definitely have to say that. I have seen a few [schools] that have really been discouraging and I have seen a few who have just been so rewarding to go to, I would say [the most are] the middle of the road." Angie describes in some detail the contrasting receptions she has received in her schools:

Some schools you go there and they're ready waiting for you, and they've got a room set up, and they're asking lots of questions. 'How do I do this?' 'Why am I doing this?'

Some schools you can give them all kinds of programs written up and ideas and they just respond sort of 'yea, yea'. You question whether there's much going on between visits.

When Angie was asked what she meant by the term 'tone' in relation to the school's reception of others she replied:

Every school seems to have their own different personality and some schools are very receptive and very gung ho on you being there and following up on things that you're suggesting. Others seem to be overworked already and 'how do you expect me to fit these things into a day?' When there's too much going on, it's hard for them.

Therapists' explained that in 'welcoming schools', educational personnel seemed to be starving for strategies or suggestions which would help them cope with the demands of the exceptional children in their classes. The teachers were desperate for assistance. Emma explains: "They're crying for help.... These classrooms are heavy duty. So when we're in to give a helping hand, they're usually very receptive." When questioned whether she felt welcome in the schools, Julie stated: "Oh definitely, definitely. When I get in the school they're always, 'Oh we're so happy to see you.' I get lots of comments like, 'We really appreciate the work you're doing.' " Lesley felt that in most situations the openness to therapy intervention was directly related to cuts in service. She explains: "Oh yea definitely because the services have been pulled back elsewhere, you know, slowly, so they'll take whatever they can get overall people are quite receptive."

Many therapists revealed they found it very difficult to enter the foreign school environment, let alone administer their therapy, on account of the reception they received from support and administrative personnel. Emma described her encounter with one particular school:

The first thing when you come in, you hope that the support staff, the administrative staff, those are your key people... And if you don't have them, chances are you won't have the rest of the school [behind you]. Like you want the support staff to be friendly, if you

have a question, photocopying, where's this classroom? Where can I find this student?

And right away when I came in that school, [they were] very defensive, they weren't helpful... they don't even say hello. You know that's a big thing! Do I sign in, where could I find a certain student? Well, there's the binders over there, look in there. Oh yea, very, very cold, not helpful. And that usually is a sign for me that this is probably not a good school, there's a lot of frustrations; chances are the teachers won't be happy either.

Surprisingly, many therapists also told of similar experiences of rejection by school personnel manifested in a variety ways. Holly said that she was truly made to feel ill at ease at one specific school. She described her experience: "I was acknowledged very superficially, it felt uncomfortable, I often felt that I had to grovel to get a room. At some places people were out and out rude. Like they rebuffed you, they sort of said, yea, we'll give you this corner, get out of here type thing!" Erin's experiences were similar: "I can remember walking into the staff room and not even being spoken to, like if you were lucky someone might tell you where the bathroom was, you're just one more person who's in there!"

Therapists indicated that their reception was very school specific. As Nicole mentioned earlier, she found that the schools she serviced in rural areas which were smaller and less culturally diverse than their urban counterparts, were highly receptive to her suggestions and interventions and very willing to go out of their way to accommodate to her recommendations. She described a particular social skills group program she was able to mount for one child which demanded a high degree of assistance and compliance from parents and the child's peers over an extended 10 week period. Her assessment of this rather unique event was, "That's very unusual, you don't really see that [in other settings]." In Ashley's experience as a specialized consultant,

she also found that in contrast to the surrounding city environment, “in the outreach component of what we do, we have been made extremely welcome.”

As well as the rural schools just mentioned, therapists found that smaller private schools were also more open to collaborating with therapists’ goals. Erin found her experiences in this school system a welcome change from the traditional public school environment. She felt that in the private school setting she was given the professional recognition she felt she deserved:

There’s much more respect for you as a professional, there’s more recognition of what you do in the private schools. Much more, they are so much more into what the kids need. All the things you hear about in the public school system, why the teachers are frustrated, it’s the antithesis, it’s just you’re starting from such a different place.

In contrast to the smaller rural and private schools, therapists found that larger institutions such as high schools were much less receptive to their interventions. Nicole attributed this difference to the size of secondary institutions: “I find that in very large schools, large numbers, which is more of a problem I find in high schools, sort of your grade 9 and 10. They’re [the student] one person in a group of many.” Jesse also felt that in high school, the large number of teachers and students made it less likely that one individual educator would take a particular interest in a child with disabilities to ensure that therapy interventions were carried out in the school setting.

From their initial entry into the school environment, the atmosphere that the therapists encountered seemed to be predictive of the characteristics of the collaborative experience they would encounter in attempting to deliver therapy. The reception was school specific and varied greatly from one setting to another with smaller rural and private schools being much more welcoming and accommodating than urban institutions, especially high schools. Most therapists

experienced a range of responses from enthusiastic welcome to complete ignorance and overt rejection. The reception received by therapists influenced their sense of belonging and subsequently their ability to integrate their interventions into the educational programming.

“On the Outside and On the Inside All at the Same Time”

The therapists revealed a contradictory relationship with the schools they visited. On the one hand in many situations their consultation and interventions were valued and sought after, however as they were not an integral part of the educational system per se, even though they might even be a school board employee, they never felt as if they truly belonged. Jesse explained the situation she faced regularly:

I know a lot of the people, the people are friendly, but you're not still part of the staff. I come to this school, the same day each week, they have a salad day lunch As consultants we're not part of that, although we're in this school the same day every week. Their Christmas parties and things, we're not invited to that because we're not part of their staff, and yet sometimes we are made to feel like staff. So it's kind of on the outside and on the inside all at the same time.

Another therapist also experienced this similar partly-in and partly-out phenomenon, however she felt that her specific discipline perhaps contributed to this feeling of being in suspension. She explains:

I guess, as a physio, I don't really feel integral, as perhaps the OT or speech [language pathologist], because they tend to go into the classrooms and actually work with the kids in the classroom, whereas we take the children out of the classroom to work with them. But we do tend to have conferences in the schools for the children that we're seeing, so you're sort of in there, but not completely you understand, half in there.

Even Sally and Cynthia, despite being school board employees working in one institution on a regular basis, both still felt peripheral to the inner core of their school. Cynthia described her low status in accommodating the essential role of accessing her students: “Every year I go into [the meetings to plan] the scheduling. I normally am the last one because, first the school [has priority], then the swimming [program], and then I organize myself [my therapy schedule] around everybody.” Sally, as noted previously, described her position as being at the bottom of the school hierarchy in relation to administrative and organizational issues. Nonetheless she asserts her position proudly: “You may be the smallest group, but you are important and you have to remind yourself that, you too are significant in education.”

Therapists from all disciplines and employment sectors clearly realized that even when they were mandated to be in the schools, and even if they were employed by educational boards, they were never really considered on par with educational personnel. Emma realistically and with insight summed up the status of therapists in the school environment: “You can’t forget that when you go into somebody’s school you’re a guest. You have to abide by their rules.”

The Value of Experience

Therapists found that as they became used to working within the school system, with experience they developed a degree of expertise and credibility with teachers and administrators, and that their feelings of estrangement diminished somewhat. Holly stated that her comfort level in the schools changed with her experience but this attitudinal transition required substantial effort on her part to prove herself. She described how this change came about:

[It] changed with experience, with my experience. Comfort level of walking into a strange environment, unfamiliar environment, and unfamiliar set of rules I’m thinking about one school where I felt very accepted, and that was after a couple of case

conferences, where you do the assessment, present the case, and then indicate what you're going to be doing with the individual child They [the teachers] felt that my role was beneficial, they saw that there were some gains that the child was making, so in that particular setting, I had no problem getting a room, I had no problem coming in whenever.

Emma described her experience of trying to make inroads into one school. Her outgoing, confident personality coupled with her persistence aided her survival and integration into the system. She described the strategies how she handled rejection:

Basically, you know, I kept on saying hello, I kept on showing them that I was here to stay, I was friendly. I guess I'm very independent and I can kind of find things myself, because I did eventually find the classrooms and I'd go in and introduce myself and basically I introduced myself to everybody and said, if you have any questions I'm here. I gave them each my card, [and said] call me and I started getting a bit of the staff members, eventually on my side.

Her frustration was evident as she continued: "Yea it took me a whole year! Absolutely, it took me a whole year." She explained her strategies further: "The first thing you have to do is you have to gain their trust. You have to be there on the days you say you're going to be there, if they ask something of you, you have to do it, cause you're trying to gain their trust." Keeping to a regular anticipated schedule was a critical element the therapists identified in building a collaborative relationship.

The Importance of a Regular Schedule

Experienced therapists working in the system stressed the essential value of establishing a consistent schedule to build trust and confidence amongst educational personnel. Under ideal

circumstances if the therapist could establish a routine, this established regular expectations on the part of school personnel and facilitated a closer working relationship. Jesse found that her regular weekly visits eased her integration into the school. “I feel comfortable because I’m here one day a week, the same day, for years, so they expect that,” she claims. However in a highly demanding and variable system after changes due to funding cuts, this regularity was often impossible, and sporadic impromptu scheduling did not contribute to the development of partnerships. Jesse continued:

I’m finding that in a lot of my schools, if I go in on an off day, they go, oh, I thought this was Tuesday! Another school I don’t have a consistent day, I only have two kids in that school, so I just go whenever. The lady at the front desk doesn’t remember me. People, they try to accommodate, but you’re not there regularly. So if you don’t hit it at quite the right time, you’re out of luck, and it takes a while to find out what are the right times, and who do I talk to.

Cynthia, whose employment status enabled her to maintain a consistent schedule, agreed that regular or anticipated visits facilitated collaboration; nonetheless, the itinerant model of therapy delivery was a deterrent to partnership development. She explained:

Another agency who supplies the schools with services on a consultant basis, they come in one morning every two weeks I think, so they don’t run on a very regular basis... They’re so spread out that they don’t get a chance to have a personal relationship with any of the people, because they don’t work together, they just come in and leave. If you were only three hours ... every two weeks in the school ... you’re not part of that team.

In general the therapists found that even when they were welcomed in the school and their professional expertise was valued, they never felt they were truly an integral part of the

educational system. They found that with experience and hard work they were able to earn the respect and collaboration they felt they deserved, however for the most part they never perceived that they were equal members of the educational team. Consistently, one of their greatest frustrations was related to the accessibility of space in which to carry out their therapy interventions.

Space - A Room of One's Own

The lack of available and appropriate space in which to treat children in schools was a consistent challenge identified by therapists and a significant factor in the effective delivery of their service. While policies promoting maximum utilization of available space may have contributed to this issue, the allocation of protected, quality space symbolized to the therapists the degree to which their services were accepted and valued within the schools that they serviced. They viewed the assignment of an appropriate work area as a sign of respect for themselves as professionals and an acknowledgement of the valuable skills they had to offer. The lack of accessibility to appropriate space on the other hand, was frequently interpreted as a symbolic gesture of the insignificant and superfluous nature of their services within the school context.

The success of educational administrators in identifying appropriate therapy space was perceived by the therapists as reflective of the degree of collaboration they could generally expect in the school environment. In one of Annie's schools, the principal went out of his way to demonstrate his commitment to her and the therapy she was offering. Accessing appropriate space was seen by both parties as a gesture of support and collaboration as revealed by Annie's explanation, "If they [the principal] say that, oh yes, we need to find you a room, if ever you have a problem with a room let me know, I'll find you something. They give up their own office

so you can do the work with the kids, because they feel that's a priority." Erin felt that the respect and support she received in the private school system, as compared to the public system, was especially well demonstrated with regards to accessing therapy space. When she was asked about the availability of usable space for treatment she replied, "Whatever you need, yea. At one private school I had a full classroom, an empty classroom, they kept it for me ... As opposed to the furnace room, it was that way in the public schools, so very different. You have more space, they're [the private schools] less crowded than the public schools."

More frequently the access to adequate treatment space was perceived by the therapists as a symbolic privilege or right, which was grudgingly given and frequently inappropriate and unusable. Many times they felt they were assigned meagre, crowded, and totally inappropriate facilities just to get them out of the way. To the therapists this gesture indicated that their services were considered insignificant, superfluous, and generally a nuisance to the schools in which they were working. Annie could not hold back her annoyance as she described her frustration with the lack of respect she experienced from school administrators: "The principal who really hardly gives you the time of day, throws you in a broom closet or something!" In several schools Holly was made to feel almost discriminated against as a health care professional and the allocation of inappropriate space was an outward gesture of avoidance and rejection. She reflected on her experience, "In other schools, I was acknowledged very superficially, it felt uncomfortable, I often felt that I had to grovel to get a room. At some places people were out and out rude. Like they rebuffed you, they sort of said, yea, we'll give you this corner, get out of here type thing! Really quite rude, and that was from a principal."

According to the therapists' reflections of their experiences, they were never made to consistently feel they were an integral part of the schools they worked in. Although they did

recount examples of where they were made to feel welcome and their services valued, just as frequently they were ignored and/or rebuffed by administrative and support personnel. Access to appropriate therapy space was frequently interpreted as a symbolic gesture of the insignificant and superfluous nature of their role within the educational context.

In this tension ridden educational environment, where therapists were considered for the most part as transient visitors, they were required to initiate and sustain collaborative relationships with a variety of personnel. This next section will describe the therapists' interactions with principals, teachers, educational assistants (EAs) (See Appendix A for definition and role), and parents.

Collaborative Partnerships in the Educational Environment

During the course of their daily activities, therapists came into contact with a large number of individuals with whom they were required to forge collaborative partnerships in order to address the specialized needs of their student clients. Communication with educational personnel, other rehabilitation health care providers, and parents was a regular requirement of the therapists' daily agenda. This section reveals the therapists' perspectives of their relationships with educational personnel including principals, teachers, and EAs, as well as their essential role with parent partners. Lesley's observations reveal the complexity of the nature of collaborative relationships that take place in schools. "There is collaboration," she admits, "But I think a lot of it varies, depends on sort of the staff that you're working with, and also, the amount of time, whether they have time to collaborate with you."

The Principal Sets the Tone

According to the perception of therapists, the principal played a key role in setting the tone and acceptance level of their involvement at all levels of the school hierarchy. The principal's intervention was crucial in establishing the supportive infrastructure to accommodate the special needs of students with physical disabilities within an inclusive environment. Therapists' commentary revealed marked diversity in the approach of principals and the commitment to inclusion in general and to the support of therapy services in particular. Their reflections focus around three themes: creating a supportive environment, the principal as facilitator/barrier, and accessing needed resources.

Creating a Supportive Infrastructure

There was general consensus among therapists that the principal played a key role in creating a receptive environment for therapy service delivery in inclusive schools. Annie felt that the principal's leadership was critical to the success of her therapy interventions. She explained: "I have found that the entire atmosphere within that school depends on the principal. I've had principals where I come in and I'm treated as a professional, they respect the work that I did, the contribution, and so are very welcoming and are very appreciative of the fact that I am coming in and offering some services." More than just setting the general climate, Holly felt that the principal defined the guidelines for school personnel's interactions with therapists. She clarified her impressions: "I think they certainly set the tone, well, they do set the tone... the acceptance, they sort of set the rules, in terms of how willing the teachers are to have strangers come into the classroom."

Both Julie and Marie highly valued the professional recognition and consideration they received from their school principals. Julie acknowledged the principal's overarching influence

on school attitudes and values: “I really feel appreciated when I go in the schools, more in some schools than others, but I guess that depends on the school principal.” Marie indicated that the principal went out of her way to ensure that Marie’s professional expertise was recognized and integrated into programming. She explains : “Je te dirais, avec la directrice, je me sens que je fais partie d’une équipe. Elle m’implique dans les décisions, elle s’assure que je sois là aux rencontres, les choses comme ça. Elle me consulte pour des dossiers, je me sens comme si on est en équipe.” (*“I can tell you, with the principal I felt that I was part of a team. She made sure that I was involved in decision-making, that I attended meetings, things like that. She consulted with me regarding students, I felt that we were a team.”*)

In one of her schools, Emma felt that her potential for intervention as a therapist was in large part dependent on the principal’s influence. She explains: “If your administration and your principal are really behind you and supportive and happy and you like them, chances are it’s going to go well.” To illustrate her point, Emma described a situation where she experienced a lack of support, which she attributed directly to inadequate direction on the part of the principal. She explained: “Basically the principal was always in her office, was really, really good friends with another teacher, they were often away they weren’t really supporting the other staff, a lot of frustrations in that school.”

Annie revealed that a lack of support from the principal rendered her efforts to develop working relationships with staff more difficult. She explained: “I might go in and the principal would have a good idea of what my role is, and how things should work in their school.” In contrast, she added, “The principal, I guess you would characterize them as less helpful and less supportive, you go in and you do your thing, but you really have to work on developing a relationship with the teachers on your own, it’s less supportive.” Thus according to the therapists,

the school personnel's attitude towards therapy intervention was derived predominately from the principal's leadership style. His or her influence facilitated or hindered their entry into the classroom.

The Principal as Facilitator/Barrier

The reception received from principals varied from school to school, with most therapists indicating they had experienced both positive and negative encounters. Jesse was of the opinion that in the schools she serviced, principals' leadership styles fell into two main types. Some were proactive serving as advocates for their pupils with disabilities. In Jesse's words: "Some principals are excellent, they support the special needs people in their school." Other principals demonstrated a more passive indifferent approach, which Jesse describes as, "A very poor attitude towards special needs people."

Establishing relationships with principals was undertaken cautiously and politically by therapists; their approach was gauged according to their interpretation of the principal's preferred leadership style. Emma describes her strategy:

I always ask, if there's a referral, how do you want the teachers to do it? If they have a question, how do you want me to handle it? Do you want them to go to you first and then you come to me? So you know, you have to follow the hierarchy of the school. A lot of principals are very possessive and they want total control. Whereas others they say, well Emma, just go with it however the teachers want, you know I'm okay with it. And if there's an issue then you can come deal with me.

The lack of formal procedures for contacting newly referred clients added to the confusion in the lines of communication.

A conflicting picture was reflected in many of the therapists' impressions and dealings with school principals. Emma described her experience with one school: "I think it's a great school, and the principal ... is a very strong advocate for special needs populations, she gets things done." Although Cynthia was guarded in her comments, her impressions revealed the tensions in her setting:

I think the principal is in principle very supportive, but he is a lay man ... he's very intense, he's definitely interested, but I think he feels awkward I think he doesn't really understand and it's not a political priority. I don't think he is against the kids, I think he likes them but I think the school is his priority, I don't think we are the priority. He is politically very correct.

Therapists encountered both subtle and overt resistance in their encounters with principals. Annie stated that she had been trying for two months to co-ordinate a meeting. She described her efforts: "The principal and I have just been mailing back and forth but most of the emails come from my end, unfortunately, and I've had a few emails that were supposedly sent to me that I never got. Anyhow there's some funny business going on, I suspect it's because the issue there is big [highly political]." Julie encountered more open resistance from a principal during a client case conference when he openly attacked her professional judgement and ethical values. She described her experience:

I had a school principal that told me when we were all sitting around the table, Mommy was there, she didn't talk a word of French ... so we had to do the presentation in English. I don't mind doing it, but the school principal minded, and he said, well I have objections to that but go ahead. I felt so bad but I said, I have to respect the mom, she's our client.

There are many possible explanations for the reactions of principals just described. Perhaps principals do not fully understand the role of therapists and the potential impact therapy can have on students with exceptionalities. Principals may consider that the school serves only as a location for therapists to deliver their services, and with such low frequencies of service the students' gains will be limited, hence why exert additional effort to accommodate therapy. Or, quite possibly, the principal may be attempting to protect teachers who are already stressed by the demands of their classroom from the extra burden of work requested by therapists. Nonetheless, regardless of the cause, the therapists perceived that in some cases principals hindered their attempts to deliver services.

Leadership on the part of principals not only facilitated the therapists' entry into the classroom, their efforts and commitment were instrumental in helping therapists acquire the resources needed by exceptional students. Therapists felt that principals were the main conduit to funding sources and their commitment was key in accessing required materials for effective therapeutic intervention. Jesse complained: "There's always some things that you need, whether it's staff assistance, or actual physical equipment that needs to be purchased. And all of that really filters down to the principal." Emma described this essential role in more specific detail:

Absolutely, I agree 100%, well because they're the ones that get the services. They have to write the letters, they have to make the phone calls. And if you don't have a principal who's rooting for you, chances are you won't get what you're supposed to have.

Thus according to the therapists, the principal's role in the school setting was critical to the success of their interventions and experience. Principals set the tone in schools and if they were supportive this attitude seemed to be shared by teachers and staff. If on the other hand principals did not see inclusion and therapy as priority issues, therapists encountered resistance at

all levels of the school hierarchy and were hindered from having access to needed equipment, space, and human resources.

Collaboration with Teachers

The therapists painted a revealing picture of the inclusive classroom and the delivery of therapeutic interventions by teachers. Their stories centered around the two inter-dependent themes: the highly demanding responsibilities they saw faced by teachers in today's classrooms, which in turn influenced the extent to which they felt the teacher is able and willing to collaborate with therapists and to apply appropriate interventions.

Dealing with the Demands of the Inclusive Classroom

According to participants, the philosophy of including all children with specialized needs in the regular school system is creating demanding, perhaps unrealistic, challenges for the teachers in inclusive classrooms. The therapists saw teachers as having to meet the multiple demands of a highly structured educational system with hugely insufficient resources. Jesse blamed continuing financial cuts and drastic changes to the educational system for teachers' limited capacity to engage in collaborative activities. Her frustrations were evident as she discussed what in her opinion has lead to the present system:

The Ministry of Education is saying that they [teachers] have to provide report cards, they have to do this, this, and this. They [teachers] don't really have time to worry about what my goals and outcomes are, and how they really should put their hands on that child, because they're lucky if they can put their hands on the child!

Many therapists felt that the complexity, diversity, and large class sizes of today's classrooms precluded even most willing teachers from being able to address individual therapy goals. Angie blamed large class complements saying, "With a child in an integrated class, the

teacher has 29 other kids to worry about, and it's really impossible for them to devote any attention to me." Emma described the intensity of the demands of the inclusive classroom in the following manner: "You still have a lack of resources. You might have two children with ADD [attention deficit disorder], another one who can't write, another one who, I don't know has got cerebral palsy, who knows? So these classrooms are heavy duty. Oh absolutely!" Sally added that teachers have inadequate preparation to develop the expertise required by the complexity and variety of students they encounter in their classes. She explained:

In the last two years the board's plan was, educate the classroom teacher, they can deal with it all. You throw all these workshops at [them], you can work with them after school. They're exhausted, so expect them to go to workshops after school? Then they're supposed to work with ADD, Tourette's, oppositional defiant, language impaired, visually impaired, you know all these children are coming into the classroom, and they're supposed to be the specialists? Doesn't work, doesn't work.

Jesse also felt that for teachers to manage these complex children effectively, they needed to acquire professional skills and knowledge, a responsibility which was difficult to master in a short period of time by individuals with insufficient medical background. She explained: "For instance in a neurologically involved client, patterns that come, tone, that is not understood by the lay people, the teachers' assistants, the teachers in the school. So you're having to educate them about that. They're busy with their other demands."

The intensity of the teachers' school day schedule was another factor which Annie felt hindered the development of strong working relationships with teachers. She described the encounters she had experienced:

Availability is a very big challenge. In the elementary school setting ... what happens is the teachers are obviously on the go all day long with their kids. They've got meetings, they've got recess to supervise, etc. So to find the time to be able to sit with the teacher, and actually talk during the day. Unless they're willing to do it on a free lunch hour, or unless you set up a specific meeting time during which time they're being relieved of their duties by someone else, it's really difficult.

Holly found the lack of available time during the day was by far the most significant factor inhibiting teacher/therapist contact. She explained:

What stands out for me is, there is so little time to collaborate, and teachers were often not available and again it was very individually based so I shouldn't overgeneralize. For instance at lunch hours, 'I am not to be disturbed', and before school and after school was sometimes difficult. It's hard to get hold of them. And also to be fair they have a lot of demands, like when they're there, they've got to produce. So it's hard to actually get some time to sit down and talk to them.

It was thus the therapists' impression that teachers in today's inclusive classrooms have excessive, unrealistic demands on their time and energy. Large sized classes, students with a variety of complex syndromes, lack of adequate preparation, and insufficient resources therapists felt limited teachers' abilities to attend to the therapeutic needs of identified children in their classrooms. It was the therapists' opinion that these factors contributed to the characteristics of the teacher/therapist partnership now to be described.

Teacher/Therapist Relationships

Therapists revealed that teachers were having difficulty adapting to the changing consultative model of therapy delivery, characterized by therapists instructing educational

personnel in the administration of appropriate therapeutic regimes. In the traditional model of school therapy delivery, which the teachers were more accustomed to, the therapist withdrew the child from the classroom to administer the required therapy directly on a one-to-one basis. Sally claimed that teachers were very supportive of this traditional model stating:

The teachers would like it when I took them out for language classes, because they knew they [the children] weren't getting the support anywhere else. So the teachers loved the withdrawal at that time because they could work with the stronger language kids at the time and I would work outside of the language group and so it wouldn't interfere with everything.

In addition to providing necessary remediation for students, according to therapists, the teachers viewed the withdrawal model as providing them with a break from problematic or excessively demanding children. Emma described the features of this mutually beneficial arrangement:

You take the student that's problematic out of the classroom, the teacher gets a break, and she has just her regular kids. The student that's having a lot of problems well, he or she's out working with the OT, so I [the teacher] can get a lot of things done with my classroom. And when you come back, it's like, oh, you're back!

Therapists felt that the transition to the consultative model of therapy has been difficult for teachers. Emma explains:

You want to know when it was the most difficult time? Is when we changed from direct therapy sessions when we would pull out the students, into consultation ... Even now sometimes when I'll go in the classroom, they'll say, oh are you going to work with them

alone, are you going to take them out? Sometimes they'll try, and they want you to take them out, you're basically liberating them from this child who's a potential problem.

The therapists revealed that their efforts to collaborate with teachers generally met with one of two responses, either overwhelming acceptance or avoidance and rejection. Marie's experiences are typical of these opposing reactions. She describes the teachers she has encountered : "J'ai eu des cas où oui, l'enseignante était très ouverte à tout ce que je lui apportais, elle va le prendre, elle va le faire, elle collabore beaucoup. Il y a d'autres enseignants où je rencontre l'enseignante [qui dit], 'j'ai comme 15 minutes, je suis pressée, ou, j'ai la pause, j'ai ci, j'ai ça'." (*"I've had clients where the teacher was very open to all that I suggested. She would take the ideas, apply them, and collaborate. There were others where I would meet the teacher and they would say, I only have 15 minutes, I'm pressed for time, I'm on break, or many other excuses. "*)

Emma found many teachers welcomed her openly into the classroom, appreciating the assistance she had to offer. She recounted her experience:

I must honestly say that I'm usually welcomed in the classroom. I've yet to meet a teacher who will say, no I don't want you in my classroom ... Teachers have large classrooms, they've got students with a lot of problems in their classrooms, so when you get that extra person in to help you, they are so receptive. Absolutely! They're crying for help!

Julie revealed that the teachers in her schools welcomed her input, however she had to carefully select the most appropriate time for an interview. She explained: "I just say okay... at recess I'll come and see you and we'll discuss five or ten minutes with the child.... but when it's within the class activities then, I'm not taking that personally, but it's just disturbing [to the class]."

Even when therapists were welcomed into the classroom, they reported that on the whole, their ability to establish effective, ongoing relationships with teachers was less than satisfactory. It was the therapists' impression that opportunities for meaningful communication were beyond the teachers' control. The excessive demands of the general classroom, group activities, and standardized processes to improve efficiency hindered teachers' willingness and ability to collaborate. According to Caroline, disrupting the norms and routines of regular educational programming to accommodate a child with special needs created understandable resistance on the part of teachers. "It's not the teachers, it's the system," she explained:

There are so many kids that are trying to get out of it [gym class], that they have to be pretty strict. And then there's me saying well can he do part of it [the gym class]? And they're like, no. And it's the system, it's not the teacher, it's not that they're not collaborating, it's because they have no choice, otherwise they'll have the entire class wanting to do only a part.

Therapists revealed that in many situations consulting with teachers, due to the factors just described, was very difficult. In fact Holly confessed she felt she was imposing when asking for teachers' collaboration. "When it came to integrating what you were doing into the classroom, it was often hard to get the teacher on line," she confesses. "I always felt like I was creating a greater workload for them, adding to it more than working for the need of the child. But, that was uncomfortable at times." Jesse claimed that she had to modify, in fact compromise, her treatment goals and expectations due to the consistent lack of carry through. She explained her dilemma:

So in terms of delivering the service, as a consultant you go in, you do an assessment, and you think, oh yea, this is what Johnny needs now, I'm going to write this up. But I have

now learned, after experience I stop right there. Because I have written so many programs that cannot be followed out because in our new and revised education system, coupled with the health care cut backs, I'm not delivering the program per se, the program isn't being done.

Many therapists working in specialized programs found that the intensity and demands on teachers' schedules prevented their essential input when children were being prescribed specific therapeutic devices. Kate commented, "I will invite the teacher to the assessment, [but] many times it's not possible for them to be freed up." In general it was the therapists' impression that their overtures to collaboration with teachers was just one more thing being imposed upon already overcharged schedules and individuals. Sally's comments reflect this general sentiment:

These teachers, my sense in the system, are so burned out because they are expected to do more than they ever were expected to do. They don't want to talk about what they could do in the classroom, it's beyond that. If you come to the door, don't talk to me about I've got an idea for your class!

In the inclusive classroom, the teacher is the key collaborator with whom therapists must share goals and suggestions to integrate therapy into classroom activities. While ideal in principle, the therapists found that teachers in today's inclusive classrooms are overburdened with large numbers of students with diverse and complex medical and psychological needs. Ministry demands and academic curricula leave little flexibility or room for creative approaches for teachers to address individual students' specialized needs. In fact, therapists were of the impression that even when teachers were receptive and open to their overtures, the integration of therapy into the classroom was just one more thing being superimposed on their already overburdened schedules, and frequently there was little follow through with prescribed

programming. In many cases the role of applying direct therapy intervention was delegated to EAs and this was also proving to be problematic.

Collaboration with EAs

All therapy disciplines supported in principle the essential role of educational assistants (EAs) in the inclusive classroom. The role of the EA with children with specialized needs is to assist as necessary with the child's academic, social, and physical development within the school context (Ottawa-Carleton Catholic School Board, 2002). With tremendous demands on teachers to meet curriculum requirements in diverse classes of children, including those with special needs, it was obvious to therapists that EAs provided critical programming and support. Nonetheless participants portrayed a changing picture of EA resource availability that was less than ideal for teachers and students, and which created an acute source of frustration for therapists who were in principle delegating their therapy interventions. Therapists repeatedly expressed their concern regarding the delivery of specific therapy regimes by untrained and unskilled support workers. The therapists' stories revolve around two main themes, the changing portrait of the EA in today's school system and the dilemmas involved in delegating specialized therapy procedures to unskilled but dedicated and willing personnel.

The EA – A Changing Profile

The role of the EA, according to therapists' perceptions, is to provide the additional support required by students with special needs to enable them to participate, within their abilities, in the activities of the inclusive classroom. The EA provides essential support to the teacher and is responsible for attending to the diversified physical, psychological, and academic needs of the students to which they are assigned. The EA is thus an essential member of the education/therapy team. Therapists acknowledged the absolutely critical nature of the support

offered by these workers. According to Nicole's perspective: "There's a lot of delegation. In the cases that I see I don't know what we would do without the EA, I really don't. I think there is so much cognitive and physical interwoven there, that I don't think a single teacher, even a resource teacher, would be able to spend the time [that is needed]." Therapists revealed that EAs frequently developed a very close relationship with the children they served. Annie described one individual who played an essential role in the rehabilitation of a student. She described the relationship as one of extreme dedication and commitment on the part of the aide:

This child had a full-time educational assistant who was probably the best ... educational assistant that I've ever met. That particular person made all the difference to this child.

This person was very, very dedicated first of all, but also got to know the child very well, got to know the [therapeutic] device very well and recognized the time that was required for that background work I was talking about and implemented it. I think a lot of the credit goes to him personally, however it also goes to the school.

EAs frequently served as the main contact between the classroom and therapists working for external specialized agencies, thus lightening some of the teacher's non-academic responsibilities. This proved to be quite effective according to Kate who added, "Sometimes the teacher does come, often the EA comes in lieu of the teacher and that's okay because the EA works with the child a lot, so they have a good sense of needs." The very close relationship the EA established with the child, frequently rendered them the most important and relevant source of information about the student. Heather explained: "Generally I'll speak with the parent and say I need to speak with someone who works closely with the child at school, who would you suggest? And then that person will usually tell me, know what, you really need to speak with the EA because they do a lot of one-on-one activities with the child." This communication system

worked effectively both ways. Angie found that the EA seemed to be the most appropriate individual in terms of follow-up to discuss specific therapy goals. She added, “The EAs are quite receptive and I would address my recommendations to the EA and let them deal with it. I think it’s really hard for the teachers to be doing anything individualized for a particular student.”

Despite the absolutely essential contribution of EAs to children with special needs in the inclusive classroom, according to therapists, diminished funding has changed the role of EAs in the school system. They portrayed a changing picture of resource funding and role definition for EAs in today’s educational system. The overall number of funded assistant positions has been markedly reduced over the past several years. Jesse described the situation when she first started working in the school system: “That has changed dramatically since I started in the program ... there was pretty much a one-on-one ratio [of student to EA]. I would say in those days I prescribed programs, I knew they were being carried out and I could document the results.” In Cynthia’s setting the number of support personnel as well as licensed professionals has been steadily eroded. “We have nobody one-to-one,” she confessed. As she explained in her own words in a previous section (p. 53), the number of personnel has been reduced significantly from two full-time EAs who were able to provide students with direct treatment to one full-time, and from two full-time PTs to one, two days per week. She concludes: “You’re reducing your service pretty dramatically!”

Diminished accessibility to EAs appeared to be consistent throughout the public education system except when the student’s disability was covered by no fault automobile insurance. In this case the scenario was strikingly different as explained by Nicole:

I would say the more physically impaired kids, and I’m thinking of those that have personal care needs, that are wheelchair dependent, need assistance with toileting,

maneuvering their clothes when they toilet, usually get 100% EA and a big part of that is funded by their private auto insurance.

According to the therapists, reduction in the number of support personnel has translated into changing roles and responsibilities for the EA and has ultimately had a major effect on the child and her or his therapy program. Changing educational policies have refocused the assistant's priorities away from therapy goals; EAs' responsibilities are now directed to what the educational system views as more pressing obligations such as specific programs and behavioural issues. Cynthia reported that new regulations related to pool safety have had a major impact on the availability of EAs for therapy: "The regulations that there have to be two people with some kids in the pool even though the EAs don't do anything, they have to be there by law, so we lose them on that." She explained further: "There were always two people in the pool, they had group pool, now there has to be one-on-one because you can't legally handle more than one child [per person] in the pool, and all the EAs go for that, it's higher priority." Jesse felt that as the student composition of each classroom became increasingly complex and diverse, EAs were required to focus their attention on children who tended to be disruptive to classroom activities. She described one such experience:

In one of my schools, there are a lot of behaviour children, so EA involvement comes at the expense of those with physical disabilities because you can leave a child with a physical disability aside in the classroom, you cannot leave a behavioural child alone in the classroom. So some of my students are not getting the programming that they need because the EAs have to spend more time with other types of children.

According to therapists, the concomitant decreased numbers of funded EA positions in the educational system and the increased integration of children into the regular school system is

having a major impact on therapeutic programming received by students with special needs.

Therapists felt that in their role as consultants delegating therapy to EAs, the quality and quantity of programming received by the child was being severely compromised. This issue will now be discussed.

Delivery of Therapy Services by EAs

In the present school model of therapy service delivery, in the interest of reducing costs, the therapist serves as a consultant delegating, in effect downloading the therapeutic programming to EAs, and occasionally monitoring the child's progress. Cynthia described her consultative partnership with the EA in her setting as follows:

When I'm here I assess first of all, I set up a program, I write a report and then when I have established what I want to do, therapy wise ... then I teach the assistants the program. They basically carry it through on a daily basis and only come to me [when] I'm in, if there's a problem with the program or if I notice if anything doesn't go the way I like it. So I see them [the child] but I don't necessarily have my hands on them at that point, only to teach the others how to do it.

The concept of delegating therapy to EAs was a source of extreme frustration and concern to therapists. They first had difficulty with the underlying principle of training lay people to apply complex, professional skills which they themselves had mastered only after significant postsecondary and postgraduate training [See also Chapter 7, p. 167]. Secondly, according to their observations, participants felt that delegating treatment in this manner impacted on the quality and quantity of therapy received by the child. Cynthia, for example, stressed that EAs are, in effect, lay people without any formal training, and this status limits their ability to understand the rationale behind therapeutic techniques. She explained:

I have nobody here who's trained. They're all laymen basically, willing, motivated laymen, but nevertheless laymen, so I can't fall back on them. It's straight teaching them tricks, but they don't know why or how or, so if things change they won't report it because they don't know what to report. So it means that the controlling system is mine, and you're responsible for them and you're only here two days a week, what happens when I'm not there [is] sometimes very difficult to monitor.

Jesse felt that a lack of formal preparation limited the EAs' understanding of students' complex medical problems. As she explained earlier: "For instance in a neurologically involved client, patterns that come, tone, that is not understood by the lay people, the teachers' assistants." Furthermore, Angie asserted that this lack of sufficient background limited the EAs' ability to apply appropriate treatment. She explained: "If I make a suggestion, and then the EAs' impression of what I've taught them isn't what I meant them to learn, and then for two weeks or a month, something is being done that I hadn't intended, then you've lost a month of work." She cited an example in which inappropriate therapy had resulted in a student receiving a fracture:

There was a situation that I was involved in suggesting an exercise program; the teacher and the EA were in charge of carrying it out. The teacher, apart from my recommendations, her nature [was] to be quite vigorous and quite aggressive, that wasn't my suggestion to be that aggressive but they did cause a fracture in the student ... I laid out my program on paper but it is unfortunate for the student that it happened.

Therapists found that many times, due to heavy scheduling or other reasons, in the end children did not receive the recommended treatment. Catherine's powerlessness in this situation was obvious, "It is a huge frustration. Actually I think that many of these kids don't get very much hands on therapy." Cynthia lamented her ability to assure adequate follow-up to the EA's

application of therapy, for she observed many cases in which the child's condition regressed. This was mostly due, she felt, to the lack of on-going direct treatment, but also perhaps attributed to the arrival of a new EA. She explains: "Sometimes I don't actually see kids for weeks and then all of a sudden you see them in the corridor and you say I haven't noticed this, have I missed this? And that is because maybe they have a new EA."

As implied above, the relationship between the child and the EA is critical. Nicole experienced a situation where the student/assistant relationship compromised therapy goals. Instead of letting the child gradually develop his own autonomy, the aide initiated and anticipated every need and action. "The child became overly dependent on the aide," she explained. "They [the child] sort of stand [stood] in the shadow of their aide. So we're trying to develop more independent work habits, more independent thinking, and you've got the aide that is 10 steps ahead of them [predicting the child's needs], so that becomes a little a bit of a concern."

The assistant's consistency with the same child was of major importance. According to Annie, the EA requirements are determined annually by the school principal, according to the needs identified on yearly assessments. At the beginning of each school year EAs are rehired, but in her words: "At the end of the school year what happens with all the educational assistants, they're not working during the summer, and then they get rehired in the fall. They are not guaranteed to get rehired in the same school working with the same children." Her frustration with this process became evident as she reflected upon one particular student, "When you're doing this to the child every year it just doesn't make sense, it doesn't make any kind of fiscal sense, it really doesn't!" In many cases therapists claimed it took two to three months for an assistant to really get to know a specific child's needs. Annie explained: "Getting to know the

child, looking after toileting, feeding, getting to know all of their devices, getting them hooked up to computers at school, so that they can do writing, helping them adapt the curriculum, the amount of work is just mind boggling!” As indicated previously, therapists reported that a change in EA frequently had a regressive influence on the child’s achievement of therapeutic and academic goals.

Delegation to support personnel was an issue of continuing dissatisfaction to therapists during their daily practice. Catherine felt that the concept of EAs providing therapy ultimately compromised the quality of treatment she prescribed. “I’m struggling every day to try to figure out what’s going on with them [the children],” she argued. “I’m sorry, an EA, not even the best EA in the world can do it. They don’t have the skill level, they don’t, we are the therapists, this is what we do.” Julie also felt acutely frustrated with a system that delegated therapy to untrained individuals. She explained, “It’s the message that I feel that we’re sending, anybody can do therapy, so sometimes I don’t feel at ease with that ... we just take a volunteer and train them ... Sometimes I really question, did we study all these years just to train people to do our job?”

Collaboration with EAs was clearly an issue of tensions and contradictions for therapists. On the one hand they acknowledged the critical role played by these individuals in the integration of children with special needs into the regular school system. The therapists were of the opinion however, that the EAs’ lack of specialized health care training in many cases limited their ability to successfully and at times safely apply the required therapy. In the end many children were receiving very little, inappropriate, or no direct therapeutic intervention.

Collaboration with Parents

Essential members of the interdisciplinary team who at times tended to be omitted in discussions on collaboration are the parents of children with special needs. All therapists

acknowledged that the parental collaboration they experienced was inconsistent. “They [parents] are very varied,” claimed Annie, “Some are wonderful, and they’ll bend over backwards to help us do what they can and follow through with things, and others feel that if we’re going in to treat this child, then they don’t really have to do anything.” Under the theme of parent collaboration, therapists’ comments differed for the most part according to type of work setting; however all therapists acknowledged the tremendous burden the child with special needs placed on parents. This section is organized according to the emerging topics of burden of care, family-centered therapy, parents as advocates, and an attitude of indifference.

Burden of Care

All therapists acknowledged the tremendous burden that children with special needs placed upon their parents in terms of time, energy, and financial resources. According to therapists, implicit in their present consultant role, the expectation is that parents as well as school teaching personnel are responsible for delivering direct therapy intervention. However, according to Lesley, it is totally unrealistic to ask parents to do any more, for according to her impressions, “Parents are just, I don’t know, I think they’re really just tired, worn down.” Jesse notes a deterioration in the outcomes that children with physical disabilities are now achieving. She explains: “I think there used to be more home support, more parent support. Now we have mostly two parents working and if you have a special needs child your expenses are really high, and maybe you’re already burnt out.” According to Annie’s experiences, she feels that excessive pressures hinder the development of effective working relationships with parents. “Not all of the parents are as easy to work with as one would hope,” she states, “I think part of that comes from the fact that they have a child with physical disabilities. Really high maintenance! They have other siblings as well.”

Holly has also experienced a steady decrease in the amount of support she obtained from parents over her years of working in schools. She attributes this change to increased pressures on parents from many sources including work and home responsibilities. She questions if the consultant model of therapy is feasible in light of diminishing support from parents:

I think where it [effective collaboration] always falls apart is that the pressure of time for everybody, meaning the family, with both parents working, extra curricular activities So you're putting a little bit of extra pressure, then you're expecting them to come home and do more therapy, it's somewhat unrealistic. The consultative model is good, because if it works and you're generalizing new learning, and you're reinforcing it in a more natural way, so you're integrating the process better. However I'm not sure that what we're expecting everybody to do fits with our present social and economic climate and educational commitments.

Emma suggests that a general lack of parental support is now increasingly felt within the schools themselves; parents are so pressured, they have little additional free time to give to school activities. She adds, "It's very difficult to get parent volunteers, parents have their own jobs and chances are they have children who have high needs, so they don't want to go volunteer in the school." Finally, Annie acknowledges the substantial burden sustained by families, which limits mutual goal setting and effective communication. She explains the situation in more detail: "The family's budget is a huge factor ... because the services are just not adequate. Families are already stretched to the limit in terms of their financial resources that they cannot go and hire the services they need to make sure their children are appropriately integrated, that's a big one!"

While Pam asserts that the burden on parents in today's society is substantial, she feels that there is also a cultural component to their stress. She cites a case from her practice:

We see a lot of families, having a child with a special need is, it was a few years ago when the Somalians came, it was not their greatest crisis. Their husband was in a refugee camp, they had just lost children in the war, and they got to come here, and that [the child with special needs] was lower down.

All therapists readily acknowledged that having a child with special needs places a substantial burden on families in terms of time, stress, and finances. Instead of parents being able to provide assistance with the daily therapy requirements of their children as required with the consultative model, therapists noted that parents are under ever increasing pressures which limit or even prevent them from providing needed reinforcement. In many ways, some therapists felt that families were in need of rehabilitative intervention as much as their special needs offspring.

Family-centered Care

For the most part, therapists infrequently acknowledged the critical role of parents and their importance as integral members of the therapy team. A group of therapists from one agency stood out with regards to the compassion they demonstrated for the family unit as a whole. Pam describes the philosophy of this particular organization, “I think that we’re client and family-centered, we work very hard to be, we’re not client and family driven, but we have a collaborative focus.”

While this group of therapists verbally acknowledged adherence to such a philosophy, their comments and stories revealed that far from paying lip service to this organizational value, they held a true commitment to this belief. Margot fervently describes how therapists address not only the child’s specific needs, but also the family’s concerns and requirements:

You ... get to know the family, the child, and then that’s very consistent for a number of years There’s so many different stages that a parent goes through in terms of their

acceptance or coping with their physically disabled child. So initially they're just trying to manage with the diagnosis and the different medical issues, and then they start to be able to separate and let the child away from them. Sometimes the first time the children have almost really been looked after by other people has been at this agency.

The compassion these therapists feel for families is symbolized in Ashley's comment, "The response to it all can often be exceedingly overwhelming for a family, I don't know how they manage." Although Pam's words are straight forward, her frankness does not conceal her empathy:

I'm really the bearer of bad news. Walking is the ultimate goal for all families, so when I worked with (the younger children), I'll be the first bad guy. They're not going to walk they're not going to roll, what are they going to be able to do, are they going to be able to function?

Although addressing the child's specific needs is the main objective of these therapists, frequently the child/family goals are one and the same. Pam describes her therapy objectives as being primarily oriented towards the family unit as follows: "The reward of being able to empower parents, to understand what their full functional goals for their children are. It's not me that does it, it's really working with them, and making them understand what their children can do, what their children will not be able to do." Heather admits that the main focus of her therapy goals must be directed to parents because, as she states, "Most of the child's communication is at home." The critical nature of the ongoing, supportive relationship with families is acknowledged by Ashley. "We have to know our families," she asserts. "I think we do quite a good job of that in establishing a trusting relationship, trying to be very open, trying to make sure they understand what it is that we'll be doing, trying to deal with it, what would be our responsibility."

In sum, in contrast to the general lack of concern revealed by participants for the needs of the child/family unit and acknowledgement of their symbiotic relationship, a group of therapists in one agency (public health care) stood out by the compassion they expressed for the family unit as a whole. Their comments demonstrated their empathy for these families and truly reflected their agency's philosophy of family-centered practice.

Parental Support

Parent involvement with the child's therapy regime seemed to be directly related to the effort they expended in terms of time, energy, or finances required to obtain the necessary therapy for their offspring. Thus it was therapists in either the private sector or public health agencies who were able to describe supportive relationships they had experienced with parents. "Obviously these are parents that are very supportive of having therapy because they're willing to pay privately," explains Carol. She adds, "They're very much committed to the therapy process, they value it very highly." In public health agencies, parents were required to arrange the appointment, and transport the child to and from the facility. Caroline admitted that this effort by parents reinforced the team effort. "It's team work," she claims, "I don't take ownership... We each have our own part of the job."

Therapists in private practice claimed that parents were knowledgeable and had the financial means to pay for the treatment they felt their children needed. Parental dedication and involvement was one of the major benefits of this type of practice, a feature therapists highly valued. Erin enthusiastically elaborates on the benefits she experiences from her practice: "The best, that's also the control thing of doing private practice. Because I say, when I take kids on with parents, I'll go in every week and do programming but they've got to do sessions with them

at least once every couple of days. They have to have agreed to it, so it's a pretty nice world that I get to work in!"

In contrast to the lack of parent involvement experienced by the therapists working in schools, those in private and health agency employment revealed many examples of supreme dedication, commitment, and advocacy on the part of parents they had encountered. As Catherine mentioned in an earlier chapter, these are the parents who are not willing to accept the status quo for their children. She described further the characteristics of these highly committed parents:

They've questioned, is there nothing else out there? ... These are the parents who get personal trainers for their kids, or these are the parents who are going for hyperbaric oxygen therapy, these are the people who are pursuing every avenue that they can think of. They just think, there's got to be more, or if I can't get what I want, how am I going to get it? They're not willing to sort of say that's it!

Therapists described how strong parent advocacy was instrumental in changing school policy regarding access to resources. Both Emma and Annie witnessed the successful culmination of parents' untiring efforts. In Emma's words: "Parents were very, very vocal, very strong advocates for their child, so they got a one to one [EA]." Annie experienced the similar impact of parent efforts:

The [therapy] services were not as extensive [sufficient] for Mom, who was always pushing for more and more and more because, I mean whatever these kids get, it's never enough, just because of the constraints. Lots of phone calls, lots of letters, I don't know how she did it to get an educational assistant!

Therapists further indicated that parents' creativity, persistence, and intuitiveness were also instrumental in obtaining material resources to meet their child's needs. In Erin's practice one parent successfully acquired a major piece of necessary equipment:

His mother's very efficient in accessing different parts of the system, she's a real go-getter. I'm struggling to figure out how to get therapy balls and balance boards into the schools, like who's going to pay for that stuff. She's arranged to have one of those big cabin classrooms, you know, a Felden classroom in the school.

Pam insisted that parental support could be demonstrated in many different ways, for example:

Some families don't want to get involved with the therapy but they're great at getting resources! They've got a special needs worker, they've got the high school student coming in; it doesn't matter if they do it, their speciality was mobilizing resources for their children and getting funding.

While therapists acknowledged that parent support was crucial, it was Carol's belief that their enthusiasm must be tempered with realism:

The parents that are the most supportive of the child, realistically supportive of the child, are the ones where the child seems to do the best. Absolutely, because they not only assist the therapist but they are also really swift enough not to give their children any false hopes. They don't smother them with love and tell them everything's going to be all right when it's not and that's a hard thing for a parent to do.

In contrast to the supportive relationship with parents experienced by many therapists in private and public health agencies, therapists working directly in schools revealed a completely

different scenario. These latter therapists reported a general lack of concern in the parents of students they encountered.

An Attitude of Indifference

Most of the itinerant therapists working in the school system revealed a picture of indifference on the part of parents. It seemed that when there was no direct participation or commitment required by parents, accentuated by a lack of regular contact with therapists, parents were inclined to associate therapy with school and leave this aspect of their child's care totally to the education system. Angie reveals her frustration with the absence of parental concern: "That is a struggle, I could go six months without any contact with parents. It's rare that you get someone [parent] saying, 'Oh yea, that's great, I think I'll do that', or 'this stinks, this is ridiculous', there's no feedback essentially." Jesse added, "They're not there, they can't see the hands on, so you have a difficult time asking them to do a home program. You can ask them to come in and visit your session but they're busy, they're working, some do, but it's really difficult."

Communication with parents was an ongoing challenge reported by therapists, and for the most part it was non-existent and ineffectual. Jesse stressed that parental contact was essential especially with therapists working in a community structure void of effective interdisciplinary communication, "You are very much dependent on parents to provide information. Parents are very busy and they are already overloaded so the expectation of them being the contact is hard." Kate revealed that while she places the responsibility for feedback to her interventions on the parents, seldom is this communication forthcoming, "The family, the onus is also on them, that if there are problems they know that I won't be following up. I often do get calls, many times I don't, and I assume that things are working well, we have no mechanism to know what percentage are."

Therapists told of their repeated and frustrating efforts to communicate with parents.

According to Angie:

At the end of the day nobody's home and they're at work and it's hard to communicate that way. I guess our service is a service to the education system primarily. The parents are aware, but it's really hard to keep them involved. Some of our students have chaotic family lives, and the parent is not making an effort to be involved either.

Therapists indicated that the lack of communication with parents impacted significantly on therapy goals and intervention. Lack of awareness of changes in the child's medical status was a source of acute frustration to therapists. In one case Angie was at a loss as to how to proceed. She described her dilemma: "For instance we have kids going through for [minor surgery] that I've had show up at school with a cast on. They've just had their [surgery] and I haven't heard about it until they get to school and they say, 'oh yea, they said something about an injection. Do you know what that's about?' " This lack of communication can even put the child's well-being at risk. Jesse was caught in a near crisis situation when a child returned to school unannounced. She explained the situation:

A child returned to school. The mother requested that the child return on that day because I have a standard day in that school and that was known to the mother. But nobody bothered to tell me that that was the day the child was coming. So I arrive at that school and all of a sudden here is the child. I get a voice mail from his mother who tells me that she sent him to school on the bus and the most he's been up in his wheelchair since his surgery is an hour and a half. She put him on the bus at quarter to eight, and this is now nine o'clock when I am arriving at school, and the school is in a total flap, everybody's afraid of him, nobody knows what to do.

Most therapists told a tale of indifference on the part of parents related to their therapy regimes, and a feeling that it was the school's responsibility to provide what was needed for their child. Sally was exasperated with one parent who could not even make the effort to send the child to school: "Mom's tired. 'I didn't get my kid up to get onto the van', or 'we didn't have any food in the house so I didn't send him', you know, any hundred number of reasons, the kid doesn't want to come, and the parent doesn't encourage him." Annie's comments, representative of many of the therapists' experiences, reveal the ultimate resignation on the part of many parents, "I've seen parents who really don't say anything. They take the system for what it is and accept what they get."

In summary, therapists reported varying degrees of collaboration with parents. One agency prided themselves on a philosophy of family-centered care where the family unit as well as the child was in effect, considered the client. Many therapists, especially those working in private or public health care agencies revealed stories of aggressive advocacy and total dedication on the part of parents to obtain appropriate therapy for their children. Unfortunately, many therapists, predominantly those working directly in schools, painted a picture of complete indifference on the part of the parents of their clients.

Chapter Summary

In summary, this chapter has portrayed, according to the therapists' perceptions, the nature and extent of collaboration they experienced as they serviced their clients with disabilities educated in inclusive school settings. The therapists found the complexity of the school environment imposing, with each school demonstrating its own characteristic personality of welcome or rejection. The therapists perceived that they were at best always considered guests

within the foreign educational environment regardless of the frequency of their visits and the length of time they had spent in a particular school. It was the general consensus among participants that the school principal played a key role in providing the appropriate social and practical support for their therapeutic interventions.

Therapists revealed that effective collaboration in inclusive school settings was not the norm in their daily experience. Although there appeared to be willingness on the part of school personnel to collaborate, the reality of the excessive demands of today's classrooms made effective, ongoing communication with teachers virtually impossible. Many therapeutic responsibilities were being delegated to EAs; however it was the therapists' impression that reduced numbers of these support personnel and their lack of specific training was compromising the quality of therapy programming delivered. Therapists also acknowledged the excessive burdens suffered by parents of children with disabilities, which limited the establishment of effective partnerships to address therapy goals. Therapists experienced varying levels of collaboration with parents, more accurately, ranging from complete indifference to mothers' aggressive advocacy and dedication. In light of the (lack of) collaborative activities just described, the proceeding chapter will describe the inclusive classroom experience and therapy service delivery for children with disabilities, as viewed through the eyes of the therapists.

CHAPTER 6: FINDINGS: THERAPISTS' PERSPECTIVES OF THE INCLUSION MODEL AND THE DELIVERY OF THERAPY SERVICES

In-depth analysis of participants' recorded interviews identified three overarching themes emerging from the data. This chapter presents the second theme, that of the portrait of the inclusive model of education, as viewed through the eyes of the therapists. This chapter addresses the second research question, "How do therapists perceive the inclusion education model influences their practice?"

According to the images portrayed by the therapists, the inclusive classroom experience, in some cases appeared to be beneficial for exceptional students. However many times it was not the idealized scenario envisaged by advocates and parents. From what she had seen in the classrooms she visited, Catherine was very sceptical about the concept of inclusion: "I feel there is integration for integration's sake and I'm not sure it's the most optimal route for a lot of kids." What participants described was an environment heavy with tension and frustration, which they felt was having a significant impact on the children and their required therapy. In an environment with marked scarcity of both human and physical resources where collaboration was sporadic or nonexistent, therapists were challenged to deliver therapy services. The inclusive experience for many children with disabilities in regular schools, as reported by the therapists, was clearly less than ideal.

This chapter examines elements of the reality of the inclusive classroom and the impact on children with disabilities as seen through the therapists' eyes. It begins with the therapists' images of how they perceived the inclusive experience was unfolding for the children within their care. This is followed by an overview of how, in participants' view, therapy services were

actually delivered and the resultant effect this was having on both the children and parents they served.

Therapists' Perceptions of Inclusion in Today's Classrooms

Therapists working in schools, in public sector agencies, and the private sector, all witnessed first hand the impact of inclusion on children with highly specialized needs. Their stories centered around three emerging themes. The discussion commences with a synthesis of the therapists' views of how generally the inclusive experience was playing out. This is followed by two key issues that they identified, namely the lack of space and equipment, which compromised their ability to deliver much needed therapy.

"Integration for Integration's Sake"

The therapists revealed a disquieting picture of how the inclusive experience was playing out in local classrooms for children with physical disabilities. While for the most part they were highly sceptical and disillusioned by what they had seen, participants were able to report several instances of where they felt the true philosophy of inclusion was actually working.

In one of Emma's schools she described a situation where, in her opinion, she felt the child was truly integrated into all classroom activities. "Cognitively there are no problems at all, she's got cerebral palsy, so she's wheelchair bound," she explained. She went on to add:

Now, she needs help for getting things out of her bag, going to the washroom, of course... [She's in a] regular classroom, participates in every classroom, music, art, always follows her group, is never, never taken away from her group. Library, computer, she participates in gym, we modify the gym activities so that she can do them. She's right in there, she's like one of the regulars.

Emma attributes the success of this experience in part to openness and flexibility on the part of school personnel especially the principal, the motivation and advocacy of parents, and a buddy system which has ensured the student always has access to the help she requires.

Nicole also described a scenario she observed where the dedication and hard work on the part of a specific physical education teacher ensured that the child was able to participate fully in all gym activities. “He is in a wheelchair ... so any activity that she [the gym teacher] has in phys ed ... he will assume a goalie position,” she explains. She adds, “He’s got the full hockey helmet and all the pads... he’ll play basketball in his wheelchair while the other ones are running... They have skating in the winter so he’s actually on the rink with his chair, they do some dance drills and he’s able to do some independent standing with a quad cane.” Holly’s impression of the benefits of inclusion are much more reserved, “Yes, I saw it work with a select few who came from a very supportive family.” Similarly to Emma and Nicole, she also adds that in her opinion, the success of a full inclusive experience is dependent upon the dedication of parents and teachers: “Parents who can work together [with teachers] and have the balance that the kids need, they know their kids... [and/or] a special teacher, like I think it depends on the individual’s personality as well. Some people can connect with a kid and help to foster that development.”

For the most part, however, the picture painted by therapists of the inclusive experience was less than ideal. When Carol was asked if she felt that the students were fully integrated she replied, “Most of them not!” In her view the child’s physical disability was a significant barrier to the development of true friendships with classmates; their school life was therefore both lonely and frustrating. She went on to explain further:

A lot of them are quite unhappy because they are not accepted by their peers because they are slightly different... They don’t look normal, they don’t walk normally. A lot of

them have communication problems so their speech is not quite normal either and this really impacts on their being accepted by their peer group... It makes it very difficult to have friends, to meet friends, and so they feel that they're outside the group and they never can meet them [friends]... Altogether it is a really difficult situation that they're in and probably a few succeed but most of them don't do too well.

As noted earlier, Catherine was highly sceptical about the inclusion model. She recalled the situation of one of her clients whose isolation by his peers at recess was so profound that he would seek ways to avoid being thrust into unstructured group activities. " [He] asks me if I can come to see him at his lunch recess because he can't do stuff with the other kids anyway." She continued: "So he would rather that I come to see him at his lunch recess because then he'll say, okay I don't have to go out for recess. He prefers to do stuff inside because he can't participate outside." She described another of her clients who in principle was integrated into the regular classroom, but in reality, was also isolated and apart from his peers. She explained further:

He's in a regular elementary school in a so-called regular classroom; basically his program is so modified at this point that he's really not in a regular program at all... he's functioning at a very low level in some things, in other things he's sort of below average... Well I think he's ostracised, not necessarily intentionally, he can't walk as fast as the other kids, he can't participate the same as the other kids, he's got an EA with him all of the time. He's not participating in regular classes, those things separate you.... It's not that the kids are necessarily mean... there's a real ostracism because of the physical disability or the cognitive disability.

Jesse has also witnessed the ostracism of children with disabilities, which she feels becomes worse as the child gets older. She has observed first hand the emotional pain and

extreme loneliness experienced by students whose physical disabilities truly isolate them from mainstream activities with their peers. She described one of her particular clients:

He can't change [direction] quickly, he also can't process information quickly because of that his eye hand co-ordination is poor. As he gets older, everybody else's gets better and his gets better but at a much slower rate. So he gets more and more ostracised because nobody wants to be his partner. The kids go out for recess, they don't want him on their soccer team... I mean talk about integration, the kids are integrated but they're ostracised. And they're talked about and a lot of them don't have any friends... I can see them in the recess yard, they'll stand against the wall, or they'll just walk around by themselves... They're sad. You ask them if they have a friend they could do something with, and they'll say no... So there's a big gap and they know it and they have to deal with it. That's one thing I think is very difficult for integration, I don't think it's for all kids depending on the magnitude of their disability.

Jesse's observations suggest that exposure to able-bodied peers does not necessarily insure that the child with disabilities will be truly included in regular class-related activities. Her comments also infer that the impact of isolation and shunning on children with disabilities has a profound emotional effect on their feelings of self-worth and self-confidence. In her opinion, this toll on the individual is a high price to pay for unquestioned faith in the inclusion philosophy.

Angie supports Jesse's belief expressed earlier, that it is easier for younger children to integrate more successfully with their peers. She adds that it is her impression that physical disabilities and minimal cognitive impairment are also facilitators to a more positive inclusive experience: "They're [the children] into play and they're not so aware of the differences between them and their neighbour. And so they're not aware that this guy can't walk, they're just like,

‘hey, this guy has a chair, is that ever neat.’ ” She has observed that in early adolescence, students are much more discriminatory, however as they continue to mature, this again seems to change. She explains: “By the time they get to junior high school then there’s a crowd that’s highly into sports which can’t accommodate the child with disabilities... and then it seems that by the end of high school there’s some compassion.”

In Angie’s opinion a cognitive impairment is the most severe detriment to integration as the child’s intellectual disability truly limits the capacity to participate in class activities and to establish meaningful relationships with peers. She describes the specific case of a child in her care:

I worked with a student who was probably cognitively at a one or two year old level, and she was in a grade six or seven class for science and geography. She was sitting and listening and being an observer, and I’m not sure that was appropriate stimulation academically, but that was her parents’ choice.

Similar to Jesse’s observation earlier, Angie also reflects on whether the belief in the inclusion philosophy is worth the cost in terms of the true impact on the children and their potential future development.

On the other end of the spectrum from the ideal of true inclusion, Jesse has observed what she terms “babying” of children who have severe cognitive and physical impairment. Rather than being integrated into class activities, these children receive special attention from their classmates which heightens their disabled status, reinforces their dependency and passivity, and prevents the development of future autonomy. She explains:

If they’re really, really disabled, then they get friends through, ‘I feel sorry for you.’ And they’ll come and almost baby them, they’ll be putting on their coat and hat and not really

realizing that the child should be doing a lot of those things. Or they'll play catch with them but they'll stand so close and just toss the ball, you know they really get babied. So you have to be really overtly handicapped to get that kind of response from another child, otherwise they're just considered, oh boy, he's really odd, you know, he's so slow, he's so dumb.

In summary, participants interviewed in this study revealed a very disillusioned opinion of the inclusive experience. While they recalled several scenarios which illustrated the cases of children successfully fully integrated into general classroom activities, for the most part therapists reported that even though the children with disabilities co-existed in the classroom with their peers, they were not considered part of the group. In fact in the therapists' view many students were lonely, isolated, and shunned by their able-bodied peers.

As will be discussed below, this less than ideal educational experience was compounded, in the therapists' opinion, by the limited therapy available to students, which in principle should have facilitated the child's participation in regular class activities. Participants reported that service delivery was hindered by space and equipment limitations.

Appropriate Space is Hard to Find

Therapists repeatedly mentioned that it was difficult to find an appropriate locale in which to administer required assessments and therapy. As mentioned in an earlier chapter, while space utilization was governed in large part by school board policies, the therapists perceived that their access to space symbolized the degree to which their services were accepted in the school environment. However regardless of their degree of acceptance, from a purely pragmatic perspective, acquiring usable space for therapy was always problematic.

In order to carry out appropriate evaluation and treatment sessions, therapists frequently required space that was large enough to hold equipment and could accommodate a variety of fine and gross motor activities. "Space is often an issue," explains Angie, "You go in there and you want to do some gross motor activities and you have a little office or you have a health room that's got photocopy supply stuff in a corner and coats in an other." From Carol's point of view, she felt that access to usable space was the main barrier she faced in delivering therapy in the schools. Space constraints were an additional challenge if the child was dependent upon large equipment such as a wheelchair. Julie's experience was typical of other therapists:

We go in schools and we want to see a child. It's going to be a small room, crowded with papers and everything. We only have a small space to work with, and you know maybe that's going to be a child that has a wheelchair, it doesn't go in.

Many of the children seen by the therapists in schools required a private location for personal reasons, or to provide an environment which was free from distraction to permit the child to concentrate on the activities at hand. General privacy for individualized treatment was a big problem for Jesse, who confessed that frequently she had to resort to major thoroughfares or confined spaces to administer her therapy sessions. "You end up in corridors or hallways, or you're given a little closet somewhere with a table and chair," she relates. "You want to do some ball skills, you want to do some running, you want to do gross motor [activities], where are you going to do it and on what?"

Angie had a particular concern with one of the children she was seeing, who was required to wear an elastic bandage over much of her body to support and conceal the extensive burns she had suffered. Angie was frustrated with her inability to deliver the required therapy in a private location. She explains the constraints:

I have a child with a burn who's got a pressure garment but there's no appropriate space in the school for them to take that off. Because the health room has windows in it, and the gym where we can play is not a private space at all. That's a concern!

Erin also admitted that privacy and the curiosity of classmates were detrimental to her therapy sessions in that her clients were unable to focus on the assigned activities. She adds, "The biggest problem was kids peeking in the window because the [play] structure was out there." Carol admitted that her ability to deliver appropriate therapy was even more difficult in the winter, as the children could not be sufficiently disrobed to permit them to move freely. She explains: "In winter, of course, it's always more difficult because the children have all these clothes on and usually when we treat them we want them in a pair of shorts and t-shirt."

Many of the therapists complained of the noise and disruptions that were a constant feature of the school environment. Jesse found she was frequently forced into hallways at recess and lunch periods to complete her charting. The constant commotion made it difficult to concentrate on assessment and program recording. Carol claimed that the constant turmoil and noise throughout the school environment interfered with her ability to deliver effective treatment. She described the working environment she was faced with: "In schools it tends to be people walking past the doors and bells going, announcements coming over the intercom, and all these things that are very distractible, and a child who is not very attentive..."

Therapists acknowledged that the inability to access appropriate space was a constant problem they faced in attempting to deliver appropriate therapy in the school environment. Adequately sized locations which provided privacy and were free from distractions were very difficult to acquire in schools being used to capacity. This difficult situation was rendered even

more problematic by the lack of available equipment to support therapy interventions and permit the child with disabilities to function in his/her school environment.

Equipment – A Scarce Resource

The lack of available equipment for evaluation and intervention in schools limited the therapists' ability to address client specific therapy goals. "How much equipment can I actually cart with me every time?" asks Jesse, who feels her effectiveness is greatly limited by the equipment she can have access to. She outlined the challenges she faces on a daily basis:

You got to go borrow whatever they have in the gym closet, and then you have to find a place to use it. Well the gym's always busy with the classes. If you're going to new schools all the time, you're having to look and see what have they got and get the key, because you don't have a key you're not on staff, so you waste a lot of time doing that.

As Jesse noted above, therapists were frequently limited to the equipment they could reasonably carry around with them from school to school. To many therapists this was an additional burden superimposed upon an already demanding schedule. Holly revealed that trudging around from school to school was fatiguing under normal circumstances, but especially more so when she was pregnant. She explains: "It was something you got used to [carrying the equipment around], you could learn to streamline but obviously something that I experienced, I mean women do experience, is when they're pregnant and doing the job. It was more taxing, from an energy point of view."

To be an efficient itinerant therapist having all the necessary equipment they would need in a day, required a great deal of planning and organization, which was carried out on their own, unpaid time. Holly found these organizational requirements a significant additional burden to her

schedule planning. “I guess what I found the hardest was in order to be productive during the treatment time, I had to be well organized the night before,” she recalls. She adds:

That meant I spent a fair bit of time planning, organizing, making sure I had all the tools that I needed like the therapy balls, the special hand writing [tools], the paper, the programs, the actual activities. So everything had to be organized the night before and that was fairly time consuming.

The travelling model of therapy delivery required ingenuity and creativity on the part of therapists if the equipment they had selected for that day was forgotten or inappropriate. Having to plan therapy equipment needs in advance, reduced flexibility in treatment planning and limited their ability to address unanticipated changes or needs. Holly explains, “So you just have to adapt it or make do with what you’ve got, or change your focus for that particular time, which is difficult to do because you have only so many times that you can see the kid. So it would mean if you miss one day, it’s hard to re-schedule.”

Obtaining the necessary funding for needed equipment to address specific children’s needs was another constant challenge faced by therapists. Erin claimed one of the biggest obstacles she encountered in her daily practice was “figuring out how to access resources within the system.” She explains, “I’m struggling to figure out how to get therapy balls, and balance boards into the schools, like who’s going to pay for that stuff?” The funding sources are now so restrained, that in many cases therapists, children, and parents are required to make very difficult choices. Jesse was faced with an especially difficult dilemma when the walking device she ordered for a child was not fully covered by government funding. She outlined the struggle and negotiations involved in trying to obtain the necessary funds:

And now we're in a situation where it isn't funded, there's an outstanding balance. Mom doesn't have the money so we are presently asking for assistance from [a charity organization] but [this agency] has been approached to send her to camp, so again [this agency] only has so much money that they can allot per child. So at the present moment, it's my understanding that the choice has to be made whether the child will go to camp or will she get an appropriate walker. So what kind of choice is that? There's a lot of equipment funding issues.

In Cynthia's practice, in order to have the equipment she needs, she shares the equipment amongst her students, "Sharing equipment, you get one for one kid and if you have more that can use it all the better. The more you say they can share it, the more likely you're going to get it." Sharing equipment creates a new set of problems however, because according to Cynthia, the equipment in theory belongs to one child while he is in the school system. If the child changes schools, the equipment follows. She explains the challenge of her "shared" solution to equipment underfunding:

Now if he moves say from one school to another, officially that equipment goes with him. So say I have this piece of equipment for kid A, and it's used by kid B, C, and D too, if I know that kid's going to leave next year, I have to apply for another frame [equipment]. I take the smallest kid and I apply for it. I get it, and then I can keep using it for a few years until that smallest kid disappears, and then I have to keep continuously track of who's leaving, what do they have, what's going to go with them? Because I have to have it replaced, because there are other kids using this equipment. I didn't know that, so things were disappearing and I thought oh! Who's was that then?

In marked contrast to therapists working in the public sector, therapists in private practice were greatly appreciative of the ease with which they were able to acquire needed equipment.

Nicole acknowledges with satisfaction the difference:

The difference from a system of [public] home care to this, when I had to prescribe equipment, I would have to do a lot more funding search. Whereas [now] I can sort of provide a wish list of all the bath aides, and transfer aides, and slant writing boards, or this type of switch, to an insurance [company], with the justification that's why we need it, and it's usually approved. So it's a very different system.

Therapists revealed that seeking funding for equipment was fraught with seemingly incomprehensible rules and irrational decision-making. Jesse found that the funding system did not appear to have any logic behind the equipment approval process. She reveals her frustration:

As a therapist I have to write letters of request and I think it depends very much on how well you can present the child's case, who you're dealing with. Sometimes I've had funding approved and sometimes I haven't and I just shake my head and go, I don't understand. I mean there is a formula and all that kind of thing, but I think it has a lot to do with your letter of presentation and who's dealing with it.

In Cynthia's experience she felt that equipment funding was for the most part related to the words one used in the application. "School funding is very finicky on its requests," she states. "You have to use the right words and the right time and you have to know those words and if those words don't occur in your requisite, forget it." She claims that the equipment funding is based on "how needy you are on paper." She continues:

Then if I don't use the right wording for multiple needs, I don't make it clear that he had other problems, or if I don't say he is severely handicapped, if I say he is heavily

handicapped. It's wording, they look for key words and if they're [the right words] not there then ... you still don't get it [the equipment]. Like we lost equipment that way, just because we didn't use [the right words].

Cynthia also revealed that government-funding deadlines hinder or even prohibit acquiring necessary equipment. In her words, "You can only order twice a year, 15th of November and 15th of March, and in-between you can't order, so if you miss your [dead]line you miss your equipment. So if you don't order in March for the kids that leave and take equipment with them, you won't have it in the fall." Cynthia revealed that when she first started working in the schools these deadlines were not well publicized. Due to the complexity of the job and the number of students it was mid-November when she realized she had equipment requirements. She learned, however, "If you don't file it, by the deadline, you don't get it... and that's very difficult, then [you'll] lose another year's equipment, that's what happened to me."

In addition, in the Francophone environment, French speaking SLPs identified specific resource deficiencies related to their practice of teaching language skills. Simple written materials, stories, and evaluation tools are only available in English. A therapist explains further: "I work in French and sometimes we don't have any material in French, we always have to translate.... Kids would benefit from working with French material, but we don't have any [French resources]. Well we have some [that we translated ourselves]... so it takes lots of our time." She added that all the language-testing materials are in English, referenced to Anglophone standards, and this creates particular challenges for her. She clarifies the problem : "La validité de ces tests n'a jamais été testée, à ce moment- là, on ne sait pas à quel point ils sont valides si on compare aux normes anglophones." (*"The validity of these tests has never been tested. At this*

point we don't know to what degree they are valid and if they are comparable to Anglophone norms.")

Another therapist explains that while language structure can be similar, English and French grammar is distinctly different. It is therefore very difficult to determine the language developmental level of a French-speaking child, using an English evaluation measure. She is forced therefore, to administer portions of her evaluations in English and others in French : "Je séparerais mon évaluation en deux, mais c'est long, et comme je suis dans un conseil francophone, je ne devrais pas être obligé de faire une évaluation en anglais." (*"I separate my assessment into two parts, but that makes it long. And because I am in a Francophone school board I should not be forced to carry out an assessment in English."*)

The lack of available therapeutic tools in French such as story cards and colouring materials also pose particular challenges identified by another Francophone SLP: "You don't have anything so you're always having to adapt to present things to the child, it's always in English. So you cannot use this material, you always have to rebuild! Rebuild! ... I'd say that would be a challenge for us working in French." Although the issues raised by these Francophone therapists are specific to the practice of speech-language pathology in any domain not just inclusive educational environments, the lack of available tools in the appropriate language was just one additional barrier faced by SLP's working in schools.

In summary, therapists working in inclusive schools revealed they encountered major obstacles in attempting to deliver therapy services within the educational setting. The lack of adequate space, equipment, and evaluation and intervention tools hindered their ability to address the therapeutic goals of their students. They were constantly challenged by a system under severe restraint in terms of physical and monetary resources, and in the end they were highly frustrated

by their limited model of therapy delivery. In the next section of this chapter, an overview of the nature of therapy services received by children with disabilities in inclusive settings is provided with an assessment of the quality from the point of view of therapists delivering the service, and their perspectives of parents on the receiving end.

Therapy Services for Children Educated in Inclusive Classrooms

Therapists expressed an overwhelming sense of frustration with the therapy services they were obliged to deliver. They seemed amazed to discover how significantly their services were eroding and at the same time almost apologetic for the quality of the interventions they were forced to deliver. This discussion begins with participants' perspectives of existing therapy services in both the public and private sector now offered to children educated in inclusive schools. This is followed by the therapists' impression of parental views of therapy services presently being received by their children. The discussion concludes with therapists' perspectives on how these therapy services are impacting on the children in their care.

"I'm Basically a Consultant"

After completing several participant interviews it became readily apparent that the therapy services available to children in inclusive schools differed significantly in the public versus the private sector. As outlined previously, within the public sector, therapy service delivery has changed over the past several years from a direct therapist/child treatment paradigm to a consultative one. In addition, therapy service delivery funding is caught within and between the bureaucracy of two major provincial ministries, namely that of Education and Health. More specifically, therapy services administered within Ministry of Education funded institutions are provided predominantly by Ministry of Health funds; there is little communication between

ministries to match the service to existing and/or changing needs. Jesse describes how in her view being caught between two ministries adds complexity to her role as a therapist:

It is a consultant model, that is our mandate, only to provide consultation.... The whole process is very difficult and very complicated, especially for us as therapists trying to provide the service. Because we are working in an institution that is Ministry of Education funded, with staff who are Ministry of Education funded, and we are trying to deliver a health care program through the Ministry of Health.

In Lesley's opinion, the move to a consultation model is purely financially driven. Her frustration and feelings of powerlessness are evident: "What's driving the consultative model is money, not efficacy; it's money. It's saving money that's what's driving it, in my mind. This province has gone down the tubes, in ten years."

In the consultative model, therapists are not remunerated for providing on-going treatment; they delegate this treatment to others. As Cynthia described in a previous chapter (p. 93) she worked primarily as a consultant. Essentially, as she described, her role is to assess the student, design an appropriate program and teach others how to apply the therapy. She seldom has any on-going direct contact with her so-called clients.

Therapists see children at varying, widely dispersed intervals, which makes continued follow-through and on-going assessment virtually impossible. Angie describes her appointment schedule as follows:

I have just a handful of kids that are on weekly intervention... For the rest of the students, the most frequent I would see them is every two weeks. We do sort of half an hour of activities together and then I send practice suggestions home or get the EA to

help the student practice between times, and the rest of the students may be seen on sort of once a month basis.

Therapy programs in schools are focused primarily on younger children based on the rationale that remediation during the early and rapid phases of a child's development will have the greatest impact on their future potential. In Angie's caseload it is the younger children that are seen most frequently at two-weekly intervals, as long as "they are making continual progress." She adds, "They sort of plateau physically in grade one or two, and it becomes more of a concern for the students to be able to focus on academic things." Sally's view of this early intervention philosophy is more cynical. She explains:

With less money, you can't do it all. So what our board does is provide service up to grade three, direct service that means assessment and consult to the teacher and the parent, and the three demos [demonstrations] on the site, that's it! ... Well when you have a system that won't provide service after grade two, you have to work really fast!

Serving as a consultant severely limits the therapeutic programming that can be provided to students. In fact, the lack of follow-through after consultation has taken place, causes many therapists to question why even bother developing the program in the first place? "You go in, you do an assessment, and you think, this is what Johnny needs now," says Jesse. She continues:

But I have now learned after experience I stop right there. Because I have written so many programs that cannot be followed out because in our new and revised education system, coupled with the health care cut backs that is, I'm not delivering the program per se, the program isn't being done!

With minimal follow-up to her treatment goals, Jesse has had to change her approach to program planning. "You have to be very specific at choosing the goal area," she explains.

“Because really, it has to be simple, the staff at the school have to be able to remember it in their head almost or they have to be able to post one little thing on the wall, so that they remember.” When it was suggested to Jesse that she create a standardized form in order to be more efficient, she protested, “These are all very individual kids they need individualized programs, individualized attention!” Therapists feel they are now trapped in a dilemma of compromising their professional expertise for the reality of the programming they know will take place, given the resource pressures which exist in inclusive classrooms. Their professional disillusionment and frustration will be discussed in the next chapter.

Lesley has worked as a therapist in both public and private systems. Her transition to private practice was motivated by her increasing professional dissatisfaction as an itinerant school therapist. She explains:

I find in most consultative models you don't really get to do that much true therapy. You do assessments, then you might model some things for family or school staff, but as far as on-going, [a] three month block of therapy, it's not there as much. Like intensive therapy, you know, people are saying they're doing therapy, but how much, if you have a zillion kids on your caseload, how much real therapy is being done? I think it's bordering on unethical, to be honest. I don't know how some people are doing it.

In her opinion, in selected cases consultation is sufficient, however she claims: “There are some types of disorders that need intensive, direct therapy at least for a good healthy block, so we're missing half of the pie.” Kate also feels that her role as a specialist prescribing highly specific and costly equipment is compromised, and the potential impact of the equipment is limited by the lack of community follow-up. “I wish that it was an ideal situation that the community [school-based therapists] had more time to follow through on some of my

recommendations, to monitor things and follow through,” she laments. “I often get the impression that the time that they can spend with clients is always being cut back, and that they’re almost consultants to the school. So if I’m a consultant and they’re a consultant, is anyone really regularly monitoring my recommendations or all recommendations that are made regarding goals and things like that?”

Therapists were generally of the opinion that therapy services have been reduced so drastically that not only were children with disabilities getting insufficient therapy to maximize their potential, they were failing to even receive the minimal intervention required to prevent their physical deterioration. Emma related the case of one of her clients who was not receiving the treatment she required:

Her basic needs are being met but even then not really, because they’re not even getting the chance to take her out of her wheelchair as often as they should, you know to be doing the stretches... If I want to make a certain recommendation I can recommend ‘til I’m blue in the face... So it might get done once a week and you know, with these students, things have to be done on a daily basis.

Caroline adds that the infrequent schedule of consultative visits are motivating many parents to seek out other sources of therapy beyond the school system in either the public or private domain. One of Caroline’s clients sought treatment with her public health care agency when the child’s condition deteriorated and problems arose, most probably due to the insufficient therapy the child was receiving in school. Caroline explains: “On a regular basis, about once every month or every six weeks, she sees the physio at school. I’m assuming that what the physio at school does, is make sure she can go up the stairs and help with gym if there’s any problem.” The child was not receiving the treatment needed and subsequently developed pain and was

unable to walk. Caroline's goals therefore were focused on addressing these two potentially avoidable problems.

In the former therapy model, therapists were employed by school boards on a salaried basis to fulfil a variety of roles including assessment, treatment, education, consultation, and equipment modification according to the job demands. All children in that setting were in principle on the caseload. However in the present model, school-based therapists are no longer remunerated for providing general advice or recommendations to educational personnel regarding children who are not specifically on their assigned list. They can only bill for those clients assigned to them by their agency. Jesse explains that when she is approached by teaching personnel to provide general consultation or information regarding a child not on her caseload she regrettably must reply: "I'm sorry I can't talk to you about that child." The present model controls both her time and the clients she can see from a legal perspective, as therapy interventions are restricted to those clients with a direct medical referral. This method of functioning is a great source of frustration to Jessie, as her counsel is sought frequently by dedicated staff for many children with complex needs who are not on her caseload. Once again she feels her professional role is being compromised and she is left with a feeling of dissatisfaction and guilt.

Therapists reported a continual turnover in school-based therapists with experienced professionals being replaced by relatively new graduates possessing limited prerequisite experience in the complex school environment, another factor contributing to the therapists' anonymity in schools. Jesse attributed this change to the following reason: "I think because of the pay and because of the frustration in not being able to deliver, because you feel like you're always compromising." Experienced therapists felt that with the consultative mandate of the

present system, they were caught between what they were permitted to deliver under the funding model and what their experience told them was best practice. Holly explains:

I think maybe in some ways it was a detriment having more experience. Because you felt that you couldn't deal with the problem in the way that you wanted to because of the time factor, the emphasis on consultation, and the concern that the assessment was not getting to the root of the problem.

The heavy turnover of therapists and lack of experienced personnel delivering the service was also felt by many therapists to be impacting on the quality of therapy received by the children. As will be discussed presently, both therapists and parents acknowledged that evaluations carried out by inexperienced therapists failed to pick up on subtle problems, or they readily labeled or diagnosed a child after one quick interview. Participants felt that the lack of therapist consistency over an extended period of time was affecting the quality of therapy delivered. New practitioners had little opportunity to develop on-going rapport with clients and to appreciate how psychosocial factors could be impacting on the children's lives and therapeutic goals. Margot describes how the frequent changeover in therapists impacts on children and their families:

A number of changes of therapist, like from one year to the next the same child won't necessarily have the same OT or same physio. So parents report to us, that so and so Suzie therapist just got to know Johnny and then they moved or changed schools, got another job... There seems to be a lot of change of caseload in terms of when you try to find people. Every year it is a change. So maybe one therapist might have done a group of schools and then things were changed around ... I think in the interest of the community, maybe that therapist would have gotten to know that school, that group of

kids, and then there's a shift around... I do know that it is hard to keep track of where therapists go.

Jesse felt that the continual turnover in school therapists definitely prevented a holistic approach to client care as client continuity and medical/social history was lost. She reflected upon one of the students in her caseload. "Consistency has a lot to do with it, knowledge of the child, knowledge of the home situation." She explains further:

She [therapist A] has been involved with the child since the child entered the school, the other two therapists are brand new to the program this year. Therapist A has noticed a lot of changes in the child that are outside of her field, behaviour, loss of weight, things that are not her therapy discipline, but she feels it's related to extenuating circumstances. But she's the only one to notice that and she's the only one to be able to speak to that, and address that issue [because of her long-standing continuity with that child]... Changes happen slowly over time because of the population you're dealing with... That's why it's easier if you're involved with the child over a long period of time, then you can look back and say I remember when three years ago... So if you're always changing therapists, that is really a problem for everybody.

It was Erin's opinion that the consultation model is a relatively inexpensive solution to the huge challenge of meeting the therapy needs of children with disabilities in schools. This 'Band-Aid' or token approach in fact, does not even attempt to address the magnitude of the problem which exists. Erin is adamant that the consultation role alone is insufficient to meet the therapy needs of most children. She strongly expresses her views:

Not just an assessment, but they need to provide the intervention as well! Where I see it falling down now, people are getting so good at, they can label just about anything, but

what do you do about it? I think that the reason they mess up the intervention is because it's the most expensive part of the process, and it would make the biggest difference.

Lesley's impressions seem to sum up the viewpoint of most therapists:

I think through school boards, through CCAC (Community Care Access Centres), I find they're making cutbacks and making therapy requirements stricter to the point that very few [children] get much real therapy... The public sites won't really admit that they can't provide the service that is needed.

On account of this dearth of services available in the public system, many parents with financial means and additional health insurance are seeking out the advantages of private therapy.

"It's More Real Traditional Therapy!"

In sharp contrast to the model of consultative therapy in public schools, therapists working in the private sector had the liberty to actually treat their clients. "It's more real traditional therapy," states Lesley, who goes on to explain that working as a private therapist she can determine treatment goals, frequencies, and interventions according to her own professional judgement. "One of the nice things about doing private practice is you have more control over what's going on with your caseload," adds Erin. In fact, the freedom to actually provide treatment according to their evaluation of the child's therapeutic needs, was the primary motivator for many therapists to seek employment in the private sector. For the most part private practice therapists tended to have both more generalized experience with school-aged children and more specialized post-graduate professional training.

Private practice therapists appreciated being able to choose the optimal site and time to treat their clients. Carol found that many times the home setting was more appropriate than school for the following reasons: "Sometimes I see them in the schools; lately I see them at home

because it's much easier to treat them at home, where there's usually some equipment at least, and some space and some quietness."

Therapists in private practice also had the freedom to determine treatment frequencies that they felt would best suit each child's particular needs. At the onset of treatment, Carol can see a client up to three or four times a week. She elaborates further: "It depends on the child and the insurance company, what they're [the insurance company] willing to allow. But normally, so far, they have been very accepting of our recommendations." Nicole organizes her therapy schedule according to the child's tolerance and progression towards therapy goals. She explains:

A very standard frequency would be for me to see them two to three times a week, and over probably a twelve-week period. We work on blocks and then gradually decrease that to twice weekly to once weekly, and if it's a very physically involved child... we tend to up our involvement when there's a transition to a new stage.

The freedom to keep inactive clients on their caseload and re-activate therapeutic intervention as the children progressed through various transition phases provided consistency in terms of personnel and ensured that they had access to required therapy when their conditions warranted it. In effect, the private practice model more closely resembles the former model of therapy service delivery when therapists had more autonomy to define the treatment content, frequency, and schedule.

Private therapists also have the liberty to extend individual treatment sessions according to the child's tolerance and responsiveness. "We don't have the same client constraints," states Carol. "The same number of people to see, so if it takes an hour and a half, instead of an hour we stay an hour and a half, if we have the time." Carol also added that if another colleague in her association needed either physical or consultative assistance regarding one particular child, they

would willingly collaborate, even if this second individual was not funded for the visit. She explains, “If anybody’s having a problem, we phone one of the other therapists and say, do you have time to come and see this with me? If there isn’t the finances to cover it, then we just go and do it, and we’ll skip the fee.”

Private therapists felt that having the liberty to treat the child in the home or in the community provided them with a more holistic view of the child and the family unit, and thus rendered their interventions more effective. Carol explains: “If you can get a good handle on their home life, and their siblings, and happenings that go on when they’re at home, you can help better to make them more comfortable and give them the support they need.” Nicole felt that seeing children function in a variety of environments provided her with a more realistic and global understanding of their abilities and potential. “We usually start in the home and move into the school integration.” She continues:

I think we maintain the holistic view of what’s their level of functional independence at home... are the systems that are set up at school actually being used at home? I will often do a school block and intersperse that with home visits. And then become very home based in the summer time to develop community living skills and mobility skills, so it does complement.

Therapists working in private practice were able to design therapeutic approaches to address their clients’ specialized needs and to actually apply the required treatment interventions. Carol felt that the direct treatment she was able to provide was of significant benefit to her clients. “I think it [direct treatment] makes a huge difference,” she claims. “It really allows them to function in a much more normal manner. The kids [without disabilities] hate to see anyone different. If you can help them [children with exceptionalities] appear to be more normal, they’re

better at being accepted in the school.” Direct treatment intervention with parents present, from Erin’s point of view, ensured that goals and interventions would be adapted and carried out into the home environment.

Nicole appreciates the flexibility she has to treat each child according to his/her perceived needs. “I mean each child is different,” she asserts. She continues:

So each child needs a different amount of therapy. But my feeling is, the more they can have early on the better the recovery is... but you're trying to maximize their return and normalcy early on. It's good to get them on some very intensive regime to start.

Nicole added that being visible in the school several times a week early in the child’s rehabilitation facilitated acknowledgement of her professional expertise and the integration of the child’s therapy into school activities and educational goals. She explains:

I can quite easily in the first year be into a school up to three times a week for about an hour to an hour and a half... So there's a lot of visibility I find in my position, and a lot of involvement in terms of sitting in on the child's IPRC [Individual Placement and Review Committee] and providing some very concrete strategies. It's almost as though the educational goals revolve around the rehab goals as opposed to the opposite.

Private practice encouraged innovation and creativity in the development of treatment strategies. Nicole worked to organize a successful co-op placement for one of her clients in a rural area where the sensitivity of the community to the student with disabilities facilitated the finding of a successful work experience. She was also able to develop an innovative social skills group for another student on her caseload. Close collaboration with supportive teachers, peers, and parents facilitated a successful ten-week session that met one particular client’s special

needs. Being privately funded allowed her to use her time, flexibility, and professional creativity to advantage in order to address specific therapy goals.

In Lesley's opinion the impact on the child of consulting versus direct treatment was highly significant. She explains:

Well, if you took the same kid, and you said I'm just going to consult to their team, their mom and dad, maybe show them a few things. And you took their twin, and were able to do real therapy, I mean, it's night and day because you're reinforcing and modelling more, you're setting them up for success!

In summary, therapists working in the private sector greatly appreciated the professional liberty they had to develop treatment regimes according to each child's perceived needs as determined from their evaluation. Therapists in private practice had the liberty to determine the treatment frequency and to vary the therapy setting from school, to home, and community environments. They felt that all these factors enabled them to provide a more holistic and comprehensive treatment strategy to best meet each individual child's goals. In many cases, professional autonomy and the opportunity to provide direct therapy were key motivators for therapists to seek employment in the private sector.

Therapists' Perceptions of Parents' Perspectives of Therapy Delivery

Therapists in both public and private sectors revealed that parents were becoming increasingly dissatisfied with the therapy their children were now receiving through the school system. Many highly motivated parents were seeking alternate sources of therapy, predominantly in the private sector to address their children's needs. Therapists reported that first and foremost, parents were dissatisfied with the consultative model. Pam heard many complaints from parents

during the transition phase from the direct treatment model to the consultative paradigm. She makes reference to a specific case:

We have seen a number of our clients complain and say that they really feel the service has changed... They [the therapists] have a time quota, 'I have to make this many visits, I've got 30 minutes to see a child.' I had one therapist tell me, 'I have a client who had [surgery], she's [in] kindergarten, she goes to school full time next year.' In April of this year the therapist told the mother, 'I will not be able to see her more than once in her first year.' So for me I was thinking, wow, she's just six ... she [her status] may change!

In Pam's opinion, dissatisfaction with the present system is creating a two-tiered system of therapy service delivery, privileging families with financial resources. "From what we hear, the majority of our clients do not have third party insurance," she relates. "Those that do are seeking private [therapy service], they want more than consultative. We get many phone calls from parents that are not happy that they're [their children] not treated."

In Erin's private practice many committed and motivated parents seek her services due to dissatisfaction with the existing school therapy model. She outlined their issues:

A lot of the parents are concerned because there's not a lot of progress [change in treatment to reflect the child's changing status] to the visits as part of the school care program... the number of [therapy] visits are quite minimal... So it might be six or eight visits, depending on what's allocated to the student. They got their concerns that's not enough [therapy for their child at this point in their development].

She identified that issues of therapy quality, previously noted to be of concern to therapists, were also acknowledged by parents:

The other concerns are consistency of the therapists in the school care system. There seems to be a very high turnover and the experience that the therapists have. Parents are not always confident in their experience. I don't know if it's because of true lack of experience or if it's difficulty communicating to the families... When therapists are only going in once a week and the parents want very specific things... that tends to be something that can sometimes sabotage the parents' confidence in the process.

Annie was engaged privately by a mother whose child's eligibility for therapy services was completely discontinued due to changes in ministry and agency policies. She describes the scenario:

I've been hired privately to go in and observe his classroom and make recommendations... this mother was denied services because they [government funders] were making these changes [funding cuts]. So they were saying no, we are not responsible [for providing treatment]. So the mother pushed, pushed, pushed to re-establish these services.... Anyhow the conclusion was that this therapist did not have the training to offer the appropriate services; now there's just no services!

Parents also complained to Erin regarding the way that school therapists labelled their children after only one brief interview. She relates their concerns:

Therapists who don't know the children that well, they do one hour assessments and produce very sweeping observations.... I understand the parents' point of view.... The parents' concerns are that it's labelling or it's misguided, so you know it's all got on the first visit.

Holly has observed in her practice that inexperienced therapists working in the community frequently can miss important problems during their assessment. She explains:

I've noticed that some therapists with lesser experience will take the results of that [standardized] assessment and say that the child is performing within an average range.

But they're not looking at it, dare I say, with a trained eye. So that the assessment output looks good and then the parents say that they performed within an average range, why can't they do this.... So some people [therapists] were getting through the kids really fast.

In summary, it was the therapists' opinion that committed parents were becoming increasingly dissatisfied with the therapy services their children were receiving through the school system. Parents reported they resented the way their children were quickly assessed and either readily identified as normal or labelled with an instant diagnosis. Therapists observed children lose precious ground through the absence of direct intervention, and reported that parents with insurance or independent financial means were being forced to seek therapy through private sources.

"Some of Them Sort of Fall Through the Cracks!"

It was the therapists' impression that the consultative model was having both a generalized impact on all children, and a specific effect on older children with disabilities. Several therapists noted that the large number of schools and children on their caseload, coupled with the limited visits they were allotted per child, made it virtually impossible to be fully informed concerning all their students' status. "Some of them sort of fall through the cracks," Angie grudgingly admits. "I haven't seen them for some time!" Lesley added that the present piecemeal, fragmented system of therapy delivery causes many children and families to be left by the wayside, "I think that services should be provided and co-ordinated through one public agency; as it is now there are people that slide through the cracks all the time." Margot also suggests that complexity of a fractured delivery system is frequently very overwhelming for

families and in consequence, “You end up seeing that some families haven’t been seen by some medical professionals or clinics for a year or two, because either people have missed appointments ... [or] because they’re so overwhelmed by the nature [of the system].”

Cynthia describes the sense of guilt and powerlessness she experienced when, due to her limited schedule and excessive caseload, she was unable to provide direct treatment and lost touch with several of her students. She explains:

Well it’s very frustrating because you can see that kids would need it [direct treatment] and probably would do well with it. I have several kids here that were not ambulating well when I got here, they started ambulating with walkers... Some of them you feel they can really get to be an independent walker if they would be trained on a daily basis, but I don’t have the chance to get my hands on them on a daily basis not even once every three or four weeks!

With the increased emphasis on the academic curriculum in the school system and decreased opportunities for direct treatment, it was Holly’s opinion that it was now harder for children with disabilities to keep up with their peers. “I guess that there is so much for the kids to cover in their academics” she reflects. She continues:

There is less down time... You know like even eight, nine years ago, there would be so many days where they’d have like half a day of special events... They’d say okay, the kids aren’t going to enjoy that, so you can take them, and work with them... Well now they don’t have that ... And they’re [the children with disabilities] having to keep up with the demands that everybody else is, you know, in order to cover a certain chapter within a certain period of time. So they’re going to have to keep up with the work and then that’s

harder for them, so they end up using maybe adaptive devices like a tape recorder or computer, word processor, and so you're taking away from the skill development.

Many therapists noted that in students of high school age there appeared to be many factors related to therapy delivery which contributed to these individuals' loss of active function. Several therapists such as Pam identified a specific group of children who were especially feeling the impact of reduced therapy services. "We're now prepared to say, she maintains, "that there are definitely transition times when there aren't enough services out there for kids." As Angie explained earlier, in her school practice the emphasis is on the younger children, for after grade one or two they plateau physically, implying that at that point regular therapy becomes unnecessary. In Cynthia's practice as a consultant, she has experienced first hand the devastating impact of the lack of direct treatment especially on older children. She recalls her experience:

It's so bad sometimes, I don't actually see kids for weeks and then all of a sudden you see them in the corridor and you say, my goodness I haven't noticed this... Things have obviously changed and because you haven't had your hands on them... you missed it... They were walking, they were fine, they were [doing] independent transfers; they were really at an optimal level of functioning at that time, so you moved your attention to somebody who needed much more. And you get back to them, and you find the chair's outgrown or spasticity has occurred. All of a sudden they won't stand during toilet transfers, why not, and you feel you've really missed the boat.

As reported earlier, Caroline sees a teenager on an individual basis because the lack of regular treatment in the school has prevented this student from walking, "She had to go back into the wheelchair because she was in so much pain," she explains. After regular direct treatment this child's status changed dramatically: "I saw her twice a week in the beginning and now that

she's walking, it's down to once a week.” The main goal of therapy with older children, Pam feels, is to maintain them at pre-growth levels of functioning. She explains, “My very strong advocate is for the very multiply involved, where I truly believe if they're maintained, that is like the gold standard because they have so much height and weight growth. In that population to be able to maintain them to adulthood is fabulous.” Other therapists report however that the lack of time for direct intervention is causing many teenagers with disabilities to lose function.

Many therapists noted resistance on the part of high-school aged students to participate in therapy activities which further accelerated their loss of active function, notably as this occurred at a time when their bodies were going through significant growth. Erin observed that adolescents, especially males in her charge resisted having their EAs with them constantly. She felt this created role confusion for the EA, while at the same time limited the academic and social participation of the child. Jesse experienced teen-agers on her caseload who strongly resisted being removed from the classroom to participate in direct therapy activities. She describes their reactions:

A lot of kids don't want to be withdrawn from class... A lot of them have balance problems, so they're very embarrassed when you come to their classroom and ask, you know, can I take Johnny? 'Where did you go? Who are you?' All the kids keep asking and they certainly don't want [to reveal they have a problem].

In conclusion, therapists in both public and private agencies noted that the present consultative model of therapy delivery in schools was having a significant impact on students with physical disabilities. Children who were on school therapists' caseloads were seen on a consultation basis once every two weeks to once a month or even less. Many children seemed “to fall through the cracks” of an under-resourced, fragmented system, and were not receiving

the therapy they needed to progress or even maintain their laboriously acquired skills. In fact many of them, especially adolescents whose physical stature was undergoing significant change, were losing ground and had lost significant degrees of independence.

Chapter Summary

In summary, this chapter has attempted to reveal snapshots of the inclusive classroom and the impact on children with disabilities as seen through the therapists' eyes. Although participants reported examples where they saw children truly integrated into all school activities with their able-bodied peers, many participants were highly disillusioned by the inclusive experience they witnessed. Some of the children they encountered, instead of being an integral part of all academic and social activities, were shunned and ridiculed by their classmates. Therapists observed children isolated by their peers, and the physical and intellectual gaps seemed to widen as the children matured and proceeded through the grade system. Some children were pitied by their classmates and treated as babies, ironically defeating the prime objectives of the inclusive philosophy, namely that of normalization and the development of independence. Many therapists reflected on whether the principle of being integrated with their peers was worth the emotional, intellectual, and overall potential developmental costs to the individual child.

Therapists working directly in schools were dissatisfied with the therapy they were forced to deliver to their clients. They consistently lacked appropriate space and equipment to carry out effective treatment intervention. Their consultant role, which prohibited them from actually treating students, made on-going follow-through and continuous assessment impossible. Many children "slipped through the cracks" and their conditions were observed to deteriorate over

relatively short periods of time. It was the therapists' opinion that the present model of service delivery paid only lip-service to the concept of rehabilitation and in effect, children in schools were receiving minimal, if any, effective therapeutic intervention.

Professional dissatisfaction with this system was causing a heavy turnover of therapists in school-based therapy, with an influx of relatively inexperienced therapists into this system. Therapists' acknowledgement of the impact this lack of experience was playing on the quality of service delivered was also supported by parents' comments. Both parents with financial means and experienced therapists were subsequently turning to the private sector to meet their respective needs. Therapists working in private practice greatly appreciated the freedom to actually treat their clients, according to their professional decision-making process. In general they felt they were able to provide a more holistic and quality service which in turn provided them with the satisfaction they desired and expected from their profession.

The practice patterns described in this chapter accentuate a number of professional dilemmas expressed by therapists which differ distinctively according to the sector, that is public, private, private/public, in which they were employed. The next chapter presents a discussion of the professional issues identified by participants that they encountered in delivering service in this under funded, highly fragmented system.

CHAPTER 7: FINDINGS: ISSUES OF PROFESSIONALISM

Systematic review and analysis of participants' interview transcripts revealed three overarching themes emerging from the data. This final chapter of research findings presents elements related to the last theme, that of issues of professionalism. This chapter addresses the third and final research question, "What professional dilemmas do therapists encounter in their daily practice?"

Therapists providing treatment for children with disabilities educated in inclusive schools were caught in a maze of fragmented services, where resources and management models differed according to discipline, employment agency, and funding sector affiliation. As therapists attempted to deliver their services amidst the challenges identified and discussed in previous chapters, patterns emerged reflecting their professional values, beliefs, rewards, and frustrations, which were, in many regards, more closely aligned with their employment agency and/or funding sector than with their rehabilitation health discipline. Nonetheless, therapists of each therapy discipline also identified specific issues of a professional nature, which influenced their practice.

This chapter is divided into two sections. The discussion begins with emergent themes related to professional issues, namely professional support and professional autonomy. The employment sectors represented by the therapists in this study demonstrate distinctly different patterns of responses. Each professional theme will thus be presented focusing on the differing issues that emerged from each work sector. The second component of this discussion will center on the collaborative working relationships of rehabilitation therapists with each other. Woven within this content are identified issues of a strictly disciplinary nature, which also came into

play during the therapists' work activity. The discussion will conclude with the barriers and facilitators therapists identified to promoting and achieving collaborative practice and effective therapy service delivery.

As the employment sector of therapists is critical to the understanding of the content of this chapter, a brief review of the four main work sectors as outlined in Chapter 4, will now be presented. The agencies represented by therapists in this study include public education, public health care, publicly funded private (school-based therapists), and private (See Appendix G). Four therapists were employed by public education boards funded through the Ministry of Education. Six therapists were Ministry of Health employees working in public health care agencies. Four therapists were employed by a private agency that received public funds through a competitive process through the Ministry of Health (these therapists are termed school-based therapists), and six therapists were working independently or in small groups as independent practitioners funded through insurance policies or private funds.

Professional Issues Related to Employment Context

Two distinctive themes emerged from the therapists' discussions related to professional practice. First, therapists working in public education and health care facilities identified a physical and human resources infrastructure which was highly supportive and valued, while itinerant therapists (school-based therapists) on the other hand, experienced an isolated, mobile practice lacking in what they considered essential support for their professional roles. Second, professional autonomy and respect was identified as being a characteristic and highly valued element of practice by therapists in both private and public health sector agencies. The opposite end of the spectrum - controlled, mandated practice - was the norm experienced by public

education and school-based therapists which proved to be a great source of discontent and frustration. The therapists' experiences and responses to these values proved to be predictive of the degree of satisfaction or dissatisfaction each group experienced with their professional role.

A Supportive Infrastructure for Professional Practice

Therapists employed by public sector education and health agencies described a human and physical infrastructure, which supported their professional practice. School-based therapists on the other hand acknowledged a virtual absence of elements to sustain their professional role. Unexpectedly, private sector therapists revealed characteristic elements of both these groups of participants.

Public Sector Employees – Supported and Valued

Therapists working in both health care and education public sector agencies revealed these organizations had a number of physical and human resources elements in place, which supported them in carrying out their professional roles. Being situated in one geographic site, and having their own protected office space and equipment from which to co-ordinate activities was cited by therapists as providing stability supporting their professional practice. Marie found that having her own office, a computer, and a place to keep her files made a big difference to her practice. In previous work settings she did not have the office space and tools required to fulfil her job requirements. She described her situation:

Au régulier, c'est sûr que le gros problème quand on arrive dans une école, il n'y a pas de bureau, il n'y a pas de salle de travail, pas d'ordinateur dans la salle de travail, pas de téléphone ... tu n'as pas vraiment de locaux adéquats Mais je pense que ça doit faire une différence si tu as une classe qui est à toi, tu peux mettre tout dans ton bureau et c'est à moi! *(In the public system, the biggest problem we have when we work in schools, is*

there is no office, no workrooms, no computer available, no telephone... there isn't adequate working space. But I think it makes a big difference when you have a classroom of your own, you can put everything in your office and it's yours!)

As referred to in an earlier chapter, the assignment of designated, protected space symbolized to therapists that their role was considered significant and essential. Heather feels privileged to have her own office which provides the stability and infrastructure she needs to make home, school, and community visits to clients. She explains:

I would say I'm kind of lucky, I've got an office, not my own but a place. I do most of my work on site [in the agency] so primarily we're based in that facility and clients come to us for their service but I do also on occasion go out Most of it is on site, and we've got materials there that we're using, we've got systems in place ...

She elaborates further on the material support provided by her agency to support her practice:

"We have a good supply budget so every year we're buying new tests or materials that we need to do our practice ... I don't have to supply my own tools." Caroline appreciates the ready access to dedicated support personnel who are available to help her with physically intensive treatment activities:

We have an assistant that can help us, some of the kids that are bigger, you need to stretch them, you need four or five pairs of hands. I do have that support, so if I reserve the assistant, then there's no problem, then I have my four hands so that helps a lot.

Therapists mentioned that being geographically situated close to other rehabilitation professionals greatly facilitated an effective, ongoing, working relationship, which accentuated their individual and collaborative roles. Heather describes how her physical set-up facilitates ongoing communication and collaboration with others:

I think the physical proximity assists as well and we share offices. I share an office with a SLP, an OT.... You just turn to that person and ask them a question as it comes up or you overhear their conversation and you can kind of jump in and say but wait, I just spoke to them about this. I think that sort of thing is facilitated by having everybody around. It just makes it easier than having to go and ask the staff a question. People are right there ... in and out crossing paths a lot; this facilitates rapid exchange If you can't find someone to ask a question you're probably less likely to do that collaborative thing.

Pam also supports the idea that physical proximity promotes effective, supportive working relationships:

I think being on-site, I think working with the team, having access to the health records, having longevity. You may not be the treating therapist but we're a small place so if you walk in the door, you walk in the therapy area, you have a pretty good idea who they [the client] are or you talk to one of the other therapists and say, he needs ...

Therapists with one physical site as their home base also reported that the human resources structure of their agency highly supported them in their existing role as professionals and in their future professional development. Many therapists including Julie, remarked on the value of having ready access to a group of varied health professionals. She appreciates the expertise offered by the variety of team members in her organization. "We have resource persons... We work as a team, so when a child is referred to us, we have the psychologist, we have the speech-language pathologist, 'les éducateurs', we'll have 'les conseillers pédagogiques', the chief of the 'l'enfance en difficulté'." Julie feels that working within a group of specialists contributes to a more holistic approach to each child's needs, and also reinforces her own specialized professional role.

Both Pam and Caroline feel that having ready access to medical specialists and the complete medical record also facilitates their practice. Pam explains:

I have access to a full health record, and a full team. So I don't have to play telephone tag for 20 days with an orthopaedic surgeon. I may see him in the hall and say I'm going to send you an email, I'm going to go to a clinic, I might not see him everyday, but I would see him much more regularly, than somebody outside.

Caroline adds that the comprehensive medical chart allows all professionals implicated with a particular a child to have a full picture of assessment findings and treatment interventions. In highly complex cases, Margot believes that the ability to access other health providers directly is an asset in addressing a child's changing or urgent needs: "The child that has more medical complexity, we can go right to neurology or ortho clinic or nutrition clinic right in the agency."

Therapists also reported that within their agencies, they received valued personal and professional support from their practice leaders or supervisors. Julie was highly appreciative of the support provided by her team leader. She described how he demonstrated his appreciation of her efforts and that she was highly valuable to the organization:

Once in a while, he pops into my office, and says 'Julie, I know you're very busy, you're working very hard. We're putting barriers sometimes in your work, but I really want you to know that you're doing an excellent job and I'm really proud of you. He does that at least twice, maybe once every two weeks ... I think that's rewarding, he really knows that we're working really hard, and he recognizes that.

Several therapists acknowledged the role their agency played in their own professional development. When asked if she felt supported by her organization, Ashley replied:

I certainly do, and I feel that I can go and see the administrator and say I think we need to do this or I think my program needs to do this ... They listened ... I just feel that it has been very much a golden opportunity for me, and as expectations are placed on me, I try and meet those expectations, I feel challenged.

Kate has sensed a continued supportive investment by her agency, which accounts for her continuing to stay within that environment. She explains:

I've been here for almost 10 years ... Every time I wonder if I need new challenges, something comes up. I was offered the [teaching] opportunity at the university and this organization supported that. Another learning opportunity came my way and I was encouraged to follow through on that. There are committees ... and I was asked to be a member of that ... In general I've had learning opportunities that have come up, every time I've thought that, have I done every thing that I can here? Is it time to move on? Things have come my way.

Heather adds that her agency has respected her professional judgement and creative ideas:

I think there has been generally good support for me in terms of, if I have an idea for some program that I'd like to put in place, or some different way I'd like to serve a particular client. It's been quite open to doing that, within our mandate obviously, so I've been able to do interesting projects.

Therapists in the public health care and education sector remarked consistently that they highly valued the opportunities provided by their employers to participate in continuing education courses and workshops. They acknowledged that this was one of the attributes of their

work situation that they cherished the most. Ashley remarked that even though funds were limited, her agency supported her continuing development in a variety of ways. She explained:

They are very supportive of giving sufficient time to present at a workshop or go to a conference. We don't have a lot of money but whenever they can manage it, we have so many days of education leave each year. They provide in house opportunities for inservices or presentations. They will pay to send people on a course if it's required. We take students, I think there's no better way to learn something well yourself, than to teach it to somebody else. They support that, they are very supportive. We don't have a lot of money, we use what is available, but they do use it well.

Kate's agency has similarly recognized her personal learning objectives and supported her continued learning needs financially: "If I've wanted to attend a conference or something like that, very rarely has it been denied, they support us from that point of view." She does add, however, that she has not found her organization to have been especially supportive of her pursuit of research activities. She elaborates: "In terms of professional objectives that I might have, research being one of them, it hasn't been something they could really support, primarily because it really hasn't been our mandate to do that."

Caroline described the extensive supportive infrastructure provided by her facility which includes paid leave for continuing education, "I went on salary ... the days that were not on weekends, they paid for, I got my salary. They paid for tuition, they paid for me to get there, so we have good support." In addition, her facility also provides her with the resource material she feels is necessary to her practice:

I say I need this article, they will find it it's on my desk within a few days. We do have great support for that ... I wanted those books, I applied for them. I said here's the

reason why I want them, it's going to serve the kids this way, I got them, but again, you don't abuse it.

In sum, therapists working in public sector health care and education facilities highly appreciated the organizational infrastructure, which supported their professional practice. They found having their own office, even if it was shared, and having access to the material, technological, and communication devices they required used their professional skills to advantage. Therapists felt that working in close physical proximity with other professionals facilitated their practice by providing them with diverse perspectives to bounce around ideas and create solutions. Finally, therapists in this sector highly valued the personal support provided by their organization for their professional and personal development. Without exception all mentioned how greatly they appreciated the financial and salary support they received to pursue their own continuing education.

School-based Therapists – You're On Your Own!

School-based therapists (publicly funded, private agency) on the other hand, acknowledged the acute sense of isolation they experienced as itinerant workers, and remarked on the lack of financial, professional, and personal support they received in coping with their daily practice. For the most part, therapists working in school-based practice felt alone and left entirely to their own resources in developing and delivering their therapy programs. Angie describes the sense of isolation she experiences working in the school environment: "There is an element of isolation because you're on your own and on a regular day you wouldn't see anybody else that's trained [in your discipline] if you wanted to start a discussion about what you're doing." She admits that the absence of the supportive infrastructure of a cohesive team is a detriment because collaborative interaction would undoubtedly improve the quality of service

delivered to clients. She describes how the absence of a collaborative focus plays out in her practice:

The first contact that you have with the [other therapists] might be at the family conference. Everybody has gone in separately to do their assessment and we decide on our goals. If we have a conference the family shows up, the case manager, the resource teacher, the regular teacher, the EA, whatever, the physio and OT, and everybody's presenting their own thing. This is unfortunate because we need to be working on goals that are the same.

Therapists working in the school-based model did not feel that their agency supported their work as professionals, nor were they provided with any incentives to participate in continuing professional development courses. They were remunerated solely for providing client-specific interventions. As mentioned previously, other therapeutically related activities such as report writing, communicating with others, and continuing education, were all on their own time and financial resources. This proved to be an acute source of frustration, even bitterness, on the part of these therapists.

School-based therapists made reference to several essential activities, which now were not funded. Jesse explains the remuneration system: "We are not salaried employees, we are not school employees, we are not salaried health employees either. We can only bill for services billed to an individual child." As described in more detail in an earlier section, she explains that in practice, this means that if teachers or EAs have therapy issues related to a child that is not on that therapists' caseload at that time, legally and in principle, the therapist cannot intervene. Angie describes how piecework payment models that remunerate therapists only for direct contact with the child, limit potential collaboration with other professionals. "So we get paid for

our work with the client; for an assessment visit or for a intervention visit,” she explains. “But to phone the OT or whatever, and have a chat, that we’re not directly paid for. So that is a barrier to communication, just because among the 30 schools I have, I work probably with eight or nine different OTs.” The existing funding model also restricts essential communication with parents. “Now if we have a phone call with a parent for longer than 20 minutes, then we can charge for it,” Angie explains. She continues:

If it’s less than 20 minutes then we can’t. So you might do four phone calls with four different parents that are each fifteen minutes, but those are calls you can’t claim. Contact with parents is very valuable but unless you do it strategically, then you can’t get paid for it.

Thus in a system where clients and colleagues are more dispersed, making effective communication even a greater priority, the tightly circumscribed agency mandate and funding model inhibits rather than facilitates necessary contacts.

Many therapists were incensed that a recent change in fee schedule provided them with no remuneration for the production of their report, an element they felt was an essential component of quality practice. Emma describes the transition to this change:

When you see a new client, in the past you would get six visits to assess the client, and then you would have one visit to write up your report that you could bill for. So what they did now, is instead of getting six visits to assess your client, you get four visits. And you don’t get paid to write your report any more. That’s the big, big issue I think that really bothers me. Anybody can go pass [administer] a test, but who can actually sit down and look at the scores and see what it really, really means. It’s writing your report where all the work is.

Jesse feels that the therapeutic report is a critical component of the total therapeutic process. She explains:

We are not allowed to bill directly for report writing. We are not, and that to me is a very big problem because that [the report] is the basis of your foundation, or your program. You have to have a good assessment. First you have to do the good assessment, you then need time to write it up and that cannot be incorporated well into a billing. You need to go away from the environment. The school environment is absolutely chaotic, so you need to remove yourself from that environment and go write it, but we are not compensated for that, that is not allowed.

Angie reveals her frustrations with the present system, "If you want to prepare a quality report, that's not emphasized by the pay system. So I could spend an hour working on a report but whether I spend an hour or five minutes working on the report, I get paid the same amount [nothing]." As Jesse commented in an earlier section related to program development, "Why bother?"

Many therapists acknowledged that even though they were not being paid for many essential functions of their professional role, in reality they were participating in invisible labour for their agency, utilising their own unpaid time to fill in the unremunerated gaps. Holly admits she spends substantial amounts of her own time, travelling from school to school, completing paperwork, and preparing treatment plans for the following day, "Everything had to be organized the night before and that was fairly time consuming." Emma feels that therapists and their families pay a considerable cost for the number of volunteer hours they donate to their employment agency. "So what's happening now is we're taking some of our own time, our families are suffering, our own personal time is suffering as opposed to including it into a

working day.” Jesse finds that all the additional responsibilities of her job that must be accomplished on her own time leave her feeling frustrated and discouraged:

I spend most evenings writing treatment notes because I don't have time during the day, when I'm trying to see as many kids as possible When I leave my job I'm never finished, that's one thing I dislike about it very much, because I feel I never have time off, I'm never up to date. I never have done what I would like to do, because I have to fit into the mandate there's a lot of consultation that goes on after hours.

Therapists also resented the lack of support to upgrade their skills and knowledge. Angie explains: “Since coming here, I've probably been on two major courses a year, that's all funded by me, I don't get paid time to do it.” Jesse is resentful that her agency makes no contribution to her professional development, for in the long run, they would benefit from her efforts to keep up to date and learn new skills. She describes with frustration the continuing education policy in her agency:

In terms of continuing education, that's entirely your own time, money and effort It's not a really well paying job to begin with, and if you take time off to go to a course in the week, you're not given any education leave. They're expecting top quality staff and they don't pay any price for that, so we do have to do that on our own time.

School-based therapists were able to derive some element of professional support from other therapists working in the same agency. Angie describes how she accesses the support she needs:

So I call up my manager and say, this is what happened today, help me! She's great about getting back to me. Within our group ... I know one person that's a wizard [expert] at

handling and I know one person that's a brain on equipment things, so just within our group there are people who are specialized in different things.

Jesse adds that her agency does arrange opportunities for professional meetings, however they are carried out on the therapists' unpaid time. She explains, "We have things like meetings [where] somebody might present an article. The company I contract to will provide in-services but they're on your own time, in the evening or maybe at a time after school when you can't get there." Emma has had to look beyond her agency for the professional and personal support she requires. She derives most of her support from the colleagues in her agency. She explains:

I found some good friends, and we make it a point to meet on a regular basis, very informal We go have lunch and we talk about clients and family and our work place ... We've got a group that usually tend to call each other, we'll leave each other voice mails. We make it a point to meet at least once a month, very informally, and we had to have the motivation to do it ourselves. We're the ones who said, listen, I need some support workwise, so let's meet.

Emma does not find that the regular disciplinary meetings organized by her agency provide much in the way of professional support. She adds:

We do have [discipline] meetings once a month, but it's not really a good time to talk about your clients or your frustrations. It's very formal and they take minutes and it's the same people complaining, you know how it is, so much that sometimes I don't even want to go to those meetings because it's just a complaint feast by the same people, it just gets so tedious.

In sum, therapists working in the school-based model of service delivery felt isolated and completely on their own within the educational environment. The absence of an active consistent

team of professionals with whom to consult on a formal and informal basis left these therapists for the most part, to their own devices. Therapists felt totally unsupported by their employment agency and were very bitter that essential activities related to client care such as report writing, communication with professionals and parents, treatment planning and organization, had to be carried out on their own unpaid time. These therapists resented the most however, that their own continuing education activities were not supported in any way by their employer, even though the latter would reap the benefits of their increased knowledge and skills. Therapists were left to their own devices to develop personal and professional support systems to sustain them through the challenges of their working life.

Private Therapists – Isolated But Not Alone!

Similar to school-based therapists, privately employed participants also felt a certain degree of isolation as they travelled from client to client. Although Catherine enjoys the freedom offered by private practice, she resents the solitude and the travel. She explains:

Winter's been awful, there's been more than enough days when I've said 'why am I doing this? I hate this!' I don't really like driving particularly and I don't like driving in winter conditions. I don't like feeling like I'm taking my life in my hands to do my job As a person I'm better off in a social setting. I was happier in a lot of ways working in a hospital setting, where you go in and say hi, want to go for coffee? I eat my lunch in my car by myself everyday. I drive around by myself everyday and I see my patients one on one.

In order to survive this solitude, therapists in private practice have built up a strong supportive social network with colleagues. This informal structure provides them with the

opportunities for personal and professional growth. Catherine describes the professional support group several of her colleagues have developed:

We have a group within the city where we get together and do [therapy techniques], ... problem solving, that kind of stuff. Networking I guess would be the word, it meets once a month, but it's very hands on. We talk about courses that are offered, different things too, but the goal is hands on, on each other.

In Carol's practice, she too has an informal network of colleagues that she works with on a regular basis and with whom she has developed significant personal and professional rapport. She describes how it developed:

Because I work with so many children [of this diagnosis], the [other rehabilitation disciplines] that work with them too, tend to be the same people with the same children, so we all get to know each other pretty well.... We have two monthly case conferences with all the people involved, so that's very helpful too. There's always a phone, we spend a lot of time phoning each other. If there's anything that we want to discuss, to talk over, check up about the child's past or in school or whatever it might be, so there's a lot of collaboration.

Other therapists indicated that, due to their absolute freedom to determine the number of school visits per week, they are much more readily integrated into the school environment and acknowledged for the professional expertise they have to offer. In turn they receive considerable support and respect from school personnel. Nicole describes her experience: "I certainly get that kind of support through the other contractors I work with. As well, within the given schools ... you're in there so often that you do get that kind of mutual support with some of the school staff and the EAs."

Private therapists, despite their acknowledgement that isolated practice is a downside of their professional role, do receive considerable formal and informal support from other therapists working in their agency. These therapists seem committed to an informal structure of continuing education and consultation, totally initiated and controlled by themselves. While these therapists indicated they participated regularly, in fact several times a year, in advanced professional continuing education activities, they made no reference to a lack of supportive funding. It is likely that therapists in this employment sector entered this practice model well informed of the relative risks and benefits. With no expectations of external funding for continuing education, they were not disappointed or disillusioned when this support was not forthcoming.

In summary, the therapists working in public education and health care, publicly funded private (school-based therapists), and private sectors revealed highly different levels of professional support received from their employment agencies. Therapists working in public health care and education sector facilities appreciated the multiple systems in place, such as the physical infrastructure and the on-going support provided by their organization for professional and personal development. School-based therapists on the other hand, experienced a sense of professional and personal isolation in carrying out their therapeutic responsibilities. They resented the essential activities of their role they were forced to carry out on unpaid time and they were frustrated with the lack of employer support for continuing education. To survive, they created an informal, supportive infrastructure to sustain both their personal and professional development. Therapists working in private practice exhibited similar feelings of isolation associated with their practice, however the extensive professional infrastructure they nurtured provided them with the formal and informal support they required.

Professional Autonomy Versus Controlled Practice

Participant response patterns to the issue of professional autonomy followed different trends to that of professional support just described. An overarching theme arising from the interviews of therapists working directly in the schools, that is those employed by public education boards or school-based therapists, was their marked frustration with the control placed by their agency on the service delivery model. In sharp contrast, therapists engaged by public health care facilities and those in private practice revealed they had the freedom and autonomy to service clients according to perceived needs, an attribute these participants highly cherished and valued. This section will profile these two opposing perspectives commencing with the viewpoint of therapists working directly in schools.

Public Education and School-based Therapists

The frustration of public education board and school-based therapists with their limited model of service delivery was woven throughout their interviews. Their dissatisfaction focused around two main themes, namely their powerlessness to direct their own practice; and their overall disillusionment with the agencies they worked for, the services they were forced to deliver, and their profession as a whole.

As indicated previously in Chapter 5, therapists working directly in the school system (both public education and school-based therapists) were frustrated with the consultant model they were forced to abide by and the mandate which prevented them from applying direct treatment. They felt the present service delivery model was primarily financially driven, and now was so restrained that essentially it paid only lip service to providing the therapy required by their clients in schools. School-based therapists were remunerated only for direct interventions with clients on their caseload, preventing them from providing education and consultation to

educational personnel and limiting their ability to earn trust and credibility. They were required to complete many tasks on their own unpaid time, as previously discussed.

In addition to the school-based therapists' practice being tightly controlled by funding mechanisms, agency case managers also firmly regulated their activities. The case manager system seemed to exert ultimate control over what services these school-based therapists were permitted or prohibited from providing. Jesse describes how the system works:

We have to get approval to see a child from the CCAC (Community Care Access Centre); every school has a case manager. They determine within their funding which is given from the Ministry of Health, how many dollars they can afford to spend per child. ... We as therapists request so many dollars essentially, through the visits we are requesting per child. We have to predict that three months in advance; [for example] we are now in the middle of the school year, and a month ago my predictions for the end of the school term were submitted. Now I have no control over if somebody is going to go for surgery, what the home situation might be, equipment [etc.]. Now you can phone and ask for extensions, and some of them will be granted. A lot depends on the case manager you're working with, but it becomes a whole management issue. Again we're not compensated for the time it takes us to predict those visits, to request extensions, and we are not supposed to see a child without prior permission.

While essentially the therapists were under control of case managers, these individuals were responsible for excessively large numbers of cases, which the therapists felt limited the effectiveness of the case manager role. Although it was the case manager's ultimate responsibility to make critical decisions concerning therapy services, it was the therapists'

perception that they often had minimal first hand knowledge of the students under their charge.

Jesse explains her impression of the case manager's role:

We have a case manager who manages a lot of children. They come to a school for a conference; they have probably never met the child, it's a paper child to them because they are the manager of that child for all services. So we all report to that person, but they may or may not [come], if they have time some of them will come and make a point of meeting the children, but often they do not know the children, they have not seen the child. They technically manage the delivery of service.

Despite this limited knowledge of the children and families, therapists must obtain permission from case managers for changes due to unanticipated contingencies. All changes must be authorized by the case manager before the therapist can receive funding for unscheduled interventions. Jesse clarifies how the system functions:

If I go to a school and I'm met in the hallway by a teacher, and we get into a billable discussion, technically I can't bill that because I have not projected it. I can phone the case manager and tell her what happened, and within their bounds they're very good about saying okay. You can submit a bill if you have a rationale, but you can get to a period where there's no money left, or often you have very intense periods for a child There is a max I think it's ten would be the max number of visits that you would be allowed per child per month. It's very rare to get that, you have to have really extenuating circumstances.

Even in special cases such as post-surgery, where there is some acknowledgement of the increased need for direct therapy, the therapists are under the tight control of the case manager's directives. "The billing system also allows for a more intense burst but only maximum once a

week after surgery,” explains Jesse. “You can go in say for a month on a weekly basis and you have to keep discussing everything with your case manager.” There also appears to be very little flexibility in the system to respond to the unanticipated requirements of these children with complex needs. Jesse describes the situation, “In a multi handicapped setting you need more visits per child and that isn’t accounted for at all. There are certain schools that should have a different set of criteria, but it’s strictly standard.” She described in an earlier chapter, an emergency situation, which occurred when a child unexpectedly returned to school after surgery and no one was prepared to deal with him. She spent a half-day working with the school personnel and in the end, “all of those things are really not billable.”

Emma feels there has been a shift in her organization’s focus over the years. As she mentioned previously: “We used to be very client focused. I’m not saying that we’re not client focused but our decisions were always based on our clients and now I find that decisions are based on money.” While Angie is critical of the existing funding model, at the same time she believes it makes more efficient use of existing human resources. She explains:

This system values face-to-face involvement so you can’t sit in the office and waste time. In the other system you could spend three hours working on a report and two minutes with the student, but here you won’t get paid if you do it that way. So you concentrate on face-to-face with the student or the parent and then your paperwork is just to support that So I guess this system, we’re very accountable to the client and the family, making sure that we’re right out there In this system, you have to get stuff done or you won’t be paid, because you get paid per visit that you do with the client.

On the other hand, it is Jesse’s opinion that this compensation system creates inefficiencies. Remuneration for direct contact with the child, the teacher, the EA, or parents is

appropriate if plans and schedules do not change. However, in reality, with the number of students involved and the complexity of their conditions and situations, unanticipated events happen on a regular basis. “If a child is not at school on the day that you have scheduled a visit and you arrive at the school to find out, you are not entitled to bill for that child,” she explains: “Only under special circumstances, you have to get permission of your case manager.”

The lack of professional autonomy and tightly monitored funding system caused therapists to reflect seriously on the complexity and severity of the situations and clients they are required to deal with on a daily basis, and how relatively poorly they were compensated for this professional expertise. Jesse feels that in effect she is being taken advantage of in this system:

We are told we can do five to six visits a day, that doesn't still give you a very good salary. I don't want it to sound like I'm money grabbing and so you need to get at least that number of bills per day, in order to even have a low salary. This, as a professional job, is not a well paying job at all. You are not compensated for the time it takes you to drive between visits. You're lucky if you have several children in one school, that makes it easier A lot of the time I have to step outside my therapy role and don another hat in terms of management of the child, it's not all therapeutic [it is much more complex].

Having to receive permission from a manager overseer and the lack of professional autonomy to intervene as necessary is extremely frustrating for therapists. Jesse explains:

It's very degrading, it's very demoralising. I often feel, you know, I'm the professional here, I'm using my time appropriately. I feel that I put in more than enough hours in the day. Often I go home at night thinking I really wasn't well paid for that day because I don't have enough billings to cover all that I did.

Emma feels that the recent changes in funding formula should have involved consultation with therapists. She expresses her distrust:

That's very frustrating, that they thought that they could take that away from us [payment for report writing], without even consulting us. We can't get everything, that we know, and no work place is perfect. But that's what really gets to me, is that they never really sat down with the people who are making their money for them A group of women that are very educated, that are working with the clients, we know what the world is like, we know what the schools are like, we're the ones that are out there, and not to come and get our opinion!

As a consequence of all these restraints on her practice, Jesse feels that the overall service quality is deteriorating. "I think more and more I see, and even in my own practice I notice the quality is deteriorating." She adds:

We are looking at an incremental need, increasing number of children who need our service ... [Advances in medical technology] are busy saving [fragile babies and children], medications are controlling seizures, there's so much more so that these kids could make gains, could do more things if they had the input. But we're stretched too thin, way, way, way too thin.

The lack of resources to meet the increasing needs led one PT to predict that this inferior service will ultimately cause erosion of the public's faith in the profession. "Unfortunately because treatments are not ideally delivered, the outcome is compromised and people lose faith in the effectiveness of therapy intervention per se and I think that is important for the physiotherapy profession."

A SLP, bound only to consultation by her agency's mandate, expressed her extreme disillusionment with her profession as a whole. To her it was ironic to have studied several years in a graduate university program, to turn around and assign highly specialized treatment techniques to lay persons. She expresses her point of view:

When we're doing our consultation and giving the programs, sometimes I feel because [of] the lack of resources and the guidelines, that anybody can do speech-language pathology. Anybody can do therapy. You know we're going to train a volunteer and he's going to do the program because we cannot intervene with the child. So sometimes I feel that all we're doing is assessing, and we're training people, and we're sort of giving our job to others; when the resource teachers are so busy working with all the children that are assigned to them... So I guess we train people to do our job, and sometimes I don't feel comfortable with that. It's the message that I feel that we're sending, anybody can do speech-language therapy.... Sometimes I really question, I said well did we study all these years just to train people to do our job?

In summary, therapists whose practice was based directly in schools, that is public education and school-based therapists, expressed extreme frustration with their mandated model of service delivery. They resented the way they were controlled by agency policies and funding models, which in turn has led to dissatisfaction with the interventions they were forced to deliver and a general disillusionment with their profession as a whole. In sharp contrast are the perspectives of private and public health care therapists who highly value their independence and appreciate the respect they earn fulfilling their professional role.

Private and Public Health Care Therapists

Private practice therapists and those employed by public health care sector agencies highly valued the autonomy they experienced to exercise their role according to their professional judgement and expertise. They revealed that of utmost importance was their freedom to determine the site, frequency, and type of treatment intervention.

Therapists felt that being able to choose the most appropriate treatment locale benefited the child and their family, and utilized their professional expertise to advantage. As Carol mentioned previously (p. 131), being able to treat the child at home facilitated more effective and efficient treatment. With pride and satisfaction she contrasts her professional freedom to that of therapists working directly in schools:

I think working with the child in the environment we work in, we have much more freedom to do what we feel is best. We don't have the same client constraints, the same number of people to see, and you know, so if it takes an hour and a half, instead of an hour, we stay an hour and a half.

Catherine claims that having the freedom to see the children in their own homes instead of in a treatment facility lessens the burden on already stressed parents and is better suited to the child's medical and physical tolerance. She explains:

I mean it's a huge cost in terms of, not financially as much, but as a burden to the parents. You know, to sit in traffic for three quarters of an hour, haul the kid out of the car, take them in for half an hour, and so by the time the child gets there, they can't participate as much in the therapy session. They're tired, they're cranky... they just don't have the tolerance. Fatigue is a huge issue.

She adds that if appropriate, she has the liberty to see the child directly upon release from hospital with no intervening wait period, “When they get home we work in what they are able to do.”

These therapists also held in high importance their professional autonomy to treat the children according to the frequency that they deemed medically and therapeutically appropriate. Nicole describes what she appreciates the most of her professional role:

What stands out the most is to be able to give a valid estimation of what I need, how much time I need, how many sessions I need to give a child to reach certain goals. And knowing that if my justification is there I will be able to go in three times a week, four times a week.

She continues: “I think there’s a little less restriction on the frequency that I can treat somebody with, and the resources that I can use. I think it all comes down to the money part, there’s a little bit more money ... from a job satisfaction [point of view] I think the visibility is much greater.”

Carol emphasizes that in her opinion early intensive intervention is therapeutically ideal and she values the professional liberty to operate according to this conviction. She adds, “The more they can have early on the better the recovery is Normally when they first come out of the hospital we see them four or five times a week.” Catherine also acknowledges and highly values the freedom she has to treat children according to how they are progressing:

If there are ones that we feel they’re really changing, and they need a lot of really intensive therapy, we can try to see them ... That is very different from where a lot of the therapists are at, who are working in more [restrained conditions]. We have a lot of freedom. I can go in and do what I want. I go in and if I want to see somebody twice a week, I see them twice a week. You work it out. If it is very appropriate to see them three

or four days in a row because they're right at the point where we're working on something, that's what I do if I can arrange it with my schedule. What's really ideal is that I can treat patients as optimally, whatever as I want. I set my own schedule, I have the freedom to do what I want when I'm there, and nobody's saying to me you have to see [another client], isn't it time you got that person off your caseload, hey you've got to take somebody else.

Most of all, however, these therapists highly valued their freedom to actually treat their clients, rather than serving solely as consultants. When Lesley was asked what she valued most of her private practice, she replied, "Therapy!!! It's more real traditional therapy, which is rewarding to me. The autonomy and the decreased amount of politics is also appealing." She compares her situation to that of her school-based counterparts:

That's why I think it's frustrating for a lot of therapists who are all consultants now, where we do half the job that we're trained for and the therapy element is missing, at least ongoing therapy. I also think the service delivery models that are taking place in a lot of the public sites are very frustrating because it's gone to all consultation ... I don't think anybody has really gone into that job for the money and if you're not getting the job satisfaction, there's lots of things you can do to make \$55,000 a year. So for me the private gives me more job satisfaction. Public jobs, right now people put up with it, even if you don't like the models that are out there, but they give you the security and benefits.

Having the autonomy to exercise their professional skills and judgement, therapists working in the private and public health care sectors were proud of their professional roles and highly valued the respect they felt they deserved. Caroline reveals that she has worked hard to earn the professional respect she now enjoys. "We earned that in the sense that we proved

ourselves, we proved that we have good success,” she explains. “Our success rate is good ... as a team we’ve earned it My professional opinion is respected and there’s no, well you can’t do this or you can’t do that or you’re spending too much time with that patient, there’s no such a thing.” Caroline’s words display the pride she derives from her professional autonomy, “I’m the one who calls the shot, and I say this kid needs [treatment] I totally determine what I do. It’s up to me.” When asked if she values this autonomy she replies, “Very much, very much. But as I said I’ve earned it and I do not abuse it.”

Nicole reveals that her professional liberty and the respect she receives for her expertise are the features she values most of private practice. She elaborates:

I think the visibility is much greater, because the intensity is there right from the beginning There’s no accountability to an employer for having to work x amount of hours ... there are no frequencies imposed by somebody else You feel a little bit better about your outcomes because you know that the system is not limiting you to only going once a month I think you feel like you have a little more of a pivotal role, than coming in as a consultant.

In summary, therapists employed in school-based and public education practice demonstrated markedly different views concerning the professional autonomy they experienced as compared to their private and public health care counterparts. School therapists were highly frustrated by their powerlessness to direct their own practice. They resented the manner in which case managers, administrators, agency and school board mandates restricted their professional liberty and autonomy, trends they believed were primarily financially driven. They felt the quality of service they were forced to deliver was steadily deteriorating, leading to a general dissatisfaction with their discipline specific role and their profession as a whole. Private and

public health care therapists on the other hand, revealed they had complete professional autonomy to determine their therapeutic goals and interventions. They highly valued this liberty and frequently contrasted their favourable position to that of their colleagues in schools. In general, private and public health care therapists were highly satisfied with their professional role and the interventions they delivered. They felt they were appropriately compensated financially in terms of respect for their professional expertise.

The professional values and tensions just discussed create the underlying background for the development and existence of effective disciplinary and interdisciplinary partnerships. The second section of this chapter examines the collaborative working relationships of rehabilitation therapists with each other. The discussion will center on which disciplines were most inclined to co-ordinate their therapeutic activities and the barriers and facilitators they identified in working together.

How We Work Together to Deliver Rehabilitation Services

In the geographical region represented by this study, the delivery of rehabilitation services was highly fractured between private and public employment sectors, education and health agencies, and even among the individual rehabilitation disciplines themselves. The ideal smooth and seamless transition of student clients from one sector to another requires effective and efficient collaboration within and among disciplines. The scenarios described by therapists in this study indicated that under favourable conditions interdisciplinary collaboration within an agency was at times possible; more frequently however, inter-agency partnerships were not easily achieved and thus were not occurring on a regular basis. This discussion will commence with two emerging themes from the therapists' discourse: the first, patterns of inter and intra

disciplinary collaboration, will be followed by the second theme of collaborative goal setting practices. The section will conclude with issues the therapists identified which either facilitated or hindered their opportunities for effective mutual collaboration.

Patterns of Disciplinary Collaboration

While in principle therapists acknowledged a willingness to collaborate with each other, and health and educational personnel, their comments on collaborative practice are restrained. Holly claimed that in her practice, “I didn’t have difficulty collaborating with speech and the physios.” Erin commented guardedly, “I have to say to the best of my knowledge, there hasn’t been any problems so far.” Erin went on to add, that in her opinion, the freedom offered by private practice facilitated the scheduling required by interdisciplinary collaboration. She explained, “If [other] people are working with them [the client], one of the nice things about doing private practice is you have more control over what’s going on with your case load.” Carol voiced support for the objective of co-operative practice, however in her opinion she felt that collaboration was to some extent dependent on other therapists’ personalities. She explains: “I suppose it depends a little bit on who the other therapists are working with the children, but on the whole it’s fairly easy.”

Surprisingly, territorialism did not appear to be an issue with therapists. “You know people have not been very territorial, in our team it isn’t really [a problem]. I haven’t found that,” Heather asserts. She goes on to add:

You know there are some issues among people on a team, personality clashes and so forth. I personally have never been affected by that. I’ve always found that when I’ve been working with another [discipline], people have not tended to say ‘that’s my area.’ But I think it is something that you need to be sort of careful with.

Cynthia also did not feel that territorialism was an issue in her practice, for in her view the focus of her colleagues was centered on clients rather than competing professional roles. She clarifies her stance, “We’re not very territorial. Some people are extremely territorial; I really don’t care who does what, as long as it gets done, and that is the same with her, so there is no borders.”

Carol’s experiences were similar, “I haven’t actually found that [professional territorialism],” she states. She explains that therapists are fully aware of the very limited services available and thus in her opinion all practitioners value any therapy intervention which can be provided to address a specific child’s needs. She continues:

We tend to sort of try to work together. Some of us will do similar things with the children, and the more reinforcement they [the children] can get the better. I think we all look on it that way rather than saying you can’t do this because this is my role. We tend to consult with each other about things, be it speaking or movement of the arms or play or what ever it is, is usually a combined effort. It works really well.

In general most therapists supported Carol’s impression that the lack of therapy resources in the school and community was so restrained that access to any therapy resources took precedence over personal or disciplinary sentiments of territorialism.

In practice however, interdisciplinary collaboration among the rehabilitation disciplines was not occurring on a regular basis. In many cases the professional, physical, and personal factors to be discussed were largely responsible. Although many therapists voiced support for the principle of collaboration, their interviews revealed that they were not fully committed to working in concert with other rehabilitation practitioners. One OT stated that in her practice, “I work very closely with those community clinicians.” Further discussion of her professional

activities revealed that her coordination with other practitioners was quite limited: “I have a lot of contact with community OTs, community physios a little bit, community SLPs a little bit more.... We follow up a little bit and see how things are going and if she’s [school-based therapist] identified a concern I might re-assess or review the client’s needs.”

One discipline in particular, physiotherapy, demonstrated greater tendencies towards autonomous practice. One PT implied that from her perspective, collaboration was predominantly a professional, individual responsibility and not necessarily an overarching philosophy of general practice: “I would say it’s [collaboration] difficult. I think one on one therapists still have very good communication with community based therapists. You know, if you’ve got a client in transition there’s no question on the professional ethics side, you’re calling them, you’re sending them a note, you’re doing that sort of thing.”

Another PT was much more forthcoming concerning the need for intra and interdisciplinary collaboration. Her main responsibility and focus was limited to her individual client and the need for communication with other practitioners, in her opinion, was considered superfluous to her role. She elaborated, “We [school-based therapists] do talk, but the communication is not the best. We don’t treat together, we don’t work together. We’re two separate entities, if I can say that word.” This therapist went on to add that she personally felt responsible for the therapy a particular child was receiving as there was so little follow-up in the schools, and therefore there was little point in making the effort to collaborate. She frankly expressed her opinion:

I hate ... I’m going to say it but I don’t like it. I feel like I’m in charge of the patient. I feel like, because they’re only seeing the kid once in a blue moon, that I’m it. Like if I don’t do what I think should be done, then there’s not going to be much done for the kid. Again

in those cases that I work with, the kid is in front of me, in pain, and so I need to do something. And I see their [school-based therapists'] mandate and I could be totally wrong, but I see them as having to have the kid function within the school. And I don't see the school, I'm not there, I don't know. I guess we should talk to set goals, but our goals would be totally different. Mine would be to get the kid back to their social life and they're more, the school life, and it shouldn't, it shouldn't [be like that].

Another PT was of the opinion that for the most part, working with individuals of other disciplines who have different levels of training and experience was of little value. She explained:

Also because we're doing more ... physios pairing up, it's easier to work with. I don't know how to say it without sounding arrogant or something but, when you're working with somebody who's got the same skill level. Most of the people in our practice have done, I mean there isn't anybody who doesn't at least have a basic Bobath [advanced skill] course. I'm not saying Bobath is the end all and be all either, but there's more of an understanding of normal movement as it applies to a neurological [child] Some OTs have worked in phys med, some of them don't have the same phys med background and so for mutual goals and for sharing things, I've definitely learned lots from OTs too. I'm not trying to say it that way at all, but for an ongoing basis, we're not necessarily working on the same things.

As a group, the PTs tended to voice more support for autonomous practice, however several PTs claimed they had worked on an individual basis at times with OTs and SLPs from their own agency. One PT described a very close relationship she had developed with an OT:

So we collaborate on a lot of things. We do all the seating together, we work at them very carefully because you can miss something. She looks at different aspects of the seating than I do. I might be a little more finicky about posture, and she knows the function, so we have to sort of compromise sometimes a little bit, and the parents very often have issues as well, so yes we collaborate a lot. We do the home visits always together ... She does the fine motor, I do gross motor, and we always give each other, each other's report.

While several PTs voiced the opinion that their discipline was the most important to address the child's particular needs, OTs on the other hand seemed to value more highly the potential benefits of collaboration. Many OTs described an ease of collaboration with other professionals of similar and different disciplines. When an OT was asked how professionals of the same discipline working on one child determine their individual roles and responsibilities, she replied:

Generally what we'll do is divide it up so that I'm doing more of the gross motor and sometimes tactile programs, whatever the kids need that can be done in the home. I cover that part and the school care therapists are working more specifically on fine motor addressing a little bit more the details.

OTs felt however, that in many cases their opportunities for collaboration were limited by a general lack of awareness as to what their profession could offer. Several OTs acknowledged their frustration with the ignorance of professionals and the public concerning the role of OT and its therapeutic potential. One OT describes the difficulties she has experienced:

One comment I would hear from teachers or teachers' assistants was, well we already do that [activity you have shown me]! It was really hard to instil in them, that it wasn't just the activity but it was how you went about it. It wasn't the end product, it was the means

to the end that we were focusing on So often I think that's the difficulty with OT, [it] is that people often look at it as if you're playing with them, that you're just doing some writing exercise. But there's a whole understanding of the body dynamics and also the visual perception, and the organization, and the co-ordination, of a lot of systems in order to get the output. So you're dealing with a lot. It looks simple but you're dealing with a lot ... That is hard, and it was hard to convince people that it was important for them to pay attention to these details.

Another OT, as mentioned previously, felt that the lack of insurance coverage for private OT services when a wide variety of other quasi medical services were funded, was open acknowledgement of the general lack of public recognition for the value of OT. "Preconceived notions, there are lots of places where OT is unclear ... people have preconceived notions," she asserts. This concept of preconceived notions was further reinforced by the comments of a PT, who felt that the widely accepted and acknowledged reputation of her profession, as compared to OT, facilitated her acceptance into the classroom. She explains further:

I guess the other nice thing is being a physio. What we do is pretty well known and accepted, it's much more concrete. We're not dealing with the socialization issues in quite the same way [as OT]; we're not dealing with the cognitive issues in quite the same way, we do deal with them, but it's sort of through the back door rather than directly. People understand a physical handicap a whole lot better than they do a social handicap, so you know, I think we have a distinct advantage over the OTs. They [the students] all want to do physio, we don't have any problem having somebody not want to see us It's really great in that sense, because we've got an edge over the other therapists. Yes, they [students] don't like to miss their physio. A lot of the other times, particularly if they're

doing something difficult in OT, they're doing problems with OT, and it's hard for them, not necessarily fun, this therapy. But they really like to do the physio.

Several OTs remarked that they felt that their profession had a great deal to offer children with disabilities in the school system, however their services were under-utilized. "Working in the [school] system, there's such a huge role for OT," affirms one OT. Another OT adds, "I think it's definitely untapped. I would say it's better, there are more referrals, I would say that in terms of numbers, people are aware of it more, and understanding of what the role is." She continues:

However, I still think there's a huge ambiguity in that, it's very different for inexperienced people or people who have not met an OT or have the experience witnessing an OT's intervention ... what needs or what difficulties kids are experiencing that they could have assistance with. Unlike physio and unlike speech-therapy, they're much more recognizable and concrete.

This same OT concludes with an overall description and analysis of her profession's attributes:

Very eclectic. What we use, how we do it, we use whatever works at the time

Something I always say is that the strength of OT is its flexibility and its adaptability, and its use of activity that is interesting and fun for kids; and it's functional and productive.

That's also our greatest weakness because for the untrained observer it appears simplified, and it's very hard to talk about it But because it's soft, you know, it's really soft, but you do see the outcome of it in terms of their function later on.

Similar to the OTs previously described, SLPs also voiced a commitment that incorporated collaborative interaction. For the most part SLPs seemed to work most frequently with OTs. An SLP describes her relationship with the OTs in her practice: "I tended to interact more closely with the occupational therapist given that my needs were greater there than the

physio. We needed to share ideas, information, and we tried to support each other in terms of working on each other's' goals as well, you know within our therapy. It was just what we did.”

The SLPs identified a very specific issue that had arisen within their practice which they felt artificially split their treatment mandate, created problems with intra and interdisciplinary collaboration, and even deprived a selected group of children of much needed therapy. The issue is related to children, who due to the nature of their disabilities, are required to use augmentative communication, usually highly sophisticated computerized technology in order to communicate. One therapist describes the development of this issue:

There are three ministries who fund speech-language pathology, Health, Ministry of Education, and Community and Social services. What happens with augmentative communication is that it falls right in the middle of all three. Health [funding] tends to be the more medically related difficulties such as voice, articulation, and motor difficulties. Education is the language-based difficulties. Community and Social Services looks after children who have cognitive difficulties. Now, you take a child who is using augmentative communication They are learning some way of communicating which is not necessarily verbal, but they're also developing skills in language and comprehension and expression. So that would generally fall under here A lot of them also have cognitive issues, okay, so augmentative communication falls right in the centre there and who's going to take responsibility for it? Nobody wants it!

Due to the very intense and costly nature of the SLP services required by these children, during a period of economic cuts the Health and Education ministries arbitrarily split their mandates such that medically related speech problems were funded by the former, while

Education would provide services related to language difficulties. Lesley described what happened:

Then as resources pulled back, school care program [funded by Ministry of Health] wasn't seeing the children for direct therapy. Essentially they [school care program] played with their mandate and said 'oh no, no, no, augmentative communication that's language! That's a language issue, that's the school's problem.' They threw it back to the school. The school boards didn't have the funding, so they threw it back at them [school care service], so that the kids were left without services, right, these kids have no therapists.

Splitting the service delivery for SLP according to the definition of the problem has created confusion and inefficiencies in the system. Another SLP describes situations she has observed:

Now what's happened is in order to figure out which of those [Health or Education] will serve children in the schools, they've kind of divided who sees whom, according to the type of disorder that the child has. In this region the CCAC (Community Care Access Centre) speech pathologists [Health] will serve children who have quote speech problems. So if they have an articulation disorder, if they have a motor speech disorder, if they have stuttering, a voice disorder, they will be followed by CCAC. If they have quote, language problems, so the child may speak normally, you can understand everything they say, but they've got very poor vocabulary or sentence structure for example, those children will be followed by the school board [Education] speech-language pathologists. Many children have both issues and they're actually followed by both speech-language pathologists.

This therapist added that with the school model being primarily consultative, regardless of the funding, children are getting minimal direct treatment. She explains further: “Children who need those services, they get very little direct input. They are in theory getting services [Educated funded], they have a speech pathologist attached to them, but that person isn't necessarily doing a lot of direct treatment.” She continued, “The CCAC speech paths [Health] will go in and do [minimal] direct treatment, but what's happened in terms of children who need augmentative communication, they no longer touch that, because that isn't speech, understand?”

The situation of the children using augmentative communication is further exacerbated by lack of continuity between the agency which prescribes the communication devices and the agency delivering the services in the schools. A SLP explains:

So the [agency] will assess the child, prescribe the device, they will deliver that device, they will train whoever is in that child's environment to learn to use the device, to select vocabulary to program the device, everything they need. However, it's all done at the facility The [agency] cannot go into the school on a regular basis and follow-up and help with the progress, etc. ... There's a hole there, there's a hole between what the [agency] is offering and what needs to happen in the school setting and the home settings too.

Another SLP sums up the present situation:

A lot of kids are right in here [falling between Health and Education], who's going to treat them? Basically what do you do if the child has speech and language issues? What you do, is you determine what's more of a problem and then that person [SLP] would take that on, and work in the goals related to the other [area as well], but we can't divide the kids up! We had a very, very few number of kids who were seen by both [SLPs], but

that was a big issue as well with the two ministries. At one point they said no ... They decided if the child is being seen by either [ministry funded SLP], they could not be seen by both. A strict rule, very, very strict rule Anyhow, so yes it's a real mess!

Although this study focused on children within inclusive classrooms, therapists spontaneously described a much more interdisciplinary collaborative spirit in segregated classroom units. Emma described her experience: "You know we're a team, it's a multi approach where we're working on in OT, but we'll also do some speech at the same time. If there's a staff member there, everybody's learning and they're bringing it into the classroom, and everybody's on the same wave length." Factors unique to the segregated classroom, to be discussed presently, seem to be more conducive to forging collaborative partnerships.

Collaborative Goal Setting

While therapists in many cases described working in collaboration with others, the information revealed in the previous section suggests that collaborative goal setting among therapists was not a common occurrence. Emma stated quite frankly that in her practice each discipline was responsible for setting their own specific goals. When asked if she participated in collaborative goal setting, she replied:

No, absolutely, no, that's more difficult. We basically all do our own goals ... It's going to be develop fine motor skills, or gait training, or learning how to eat on their own, you know just a couple of examples. We have to make up our own reports with our own goals.

According to Emma, this unidisciplinary objective setting was mandated by the government agency that funded her service. Angie regretted that collaborative goal sharing did

not take place, due in large part she felt to minimal contact amongst therapists. She described the situation in an earlier section:

The communication between disciplines is at a loss... The first contact that you have with the OT or speech might be at the family conference. Everybody has gone in separately to do their assessment and we decide on our goals. If we have a conference the family shows up, the case manager, the resource teacher, the regular teacher, the EA, the physio and OT and everybody's presenting their own thing. This is unfortunate because we need to be working on goals that are the same.

While Margot stated that in her practice there was some collaborative goal setting, her words reflect a more disciplinary approach: "We're on an annual, semi-annual basis [for goal setting], review of things that are going on, so parents have input to the goals. So the goal might be... mobility, communication, some self-care, could be behavioral and learning as well, but you do look at some key goals, they tend to shift." Caroline stated quite frankly that she felt collaborative goal sharing in her practice was pointless. She explains:

My goal with that patient, we set goals together that it would be that she would use her wheelchair less, and she would walk more. She would have less pain and she would go back to the sports that she wanted to go back to. So this is what we're looking for. I think that school is much more, and again I think, I can't talk for them, but when I talk to my client, the way I see it, she's [the school therapist] more making sure she can function within the school.

Catherine echoed Caroline's sentiments, in that she felt as the other therapists were coming from different disciplines or environments, these other practitioners had little to add to her specific goals. She explains in her words:

Some OTs have worked in phys med... some of them don't have the same phys med background. So for mutual goals and for sharing things, I've definitely learned lots from OTs too, I'm not trying to say it that way at all, but for an ongoing basis, we're not necessarily working on the same things.

Although the physical factors to be discussed presently such as schedules and workloads made collaborative practice and goal sharing practically difficult, there also appeared to be a lack of motivation on the part of some therapists, notably PTs, to collaborate. While OTs and SLPs expressed a more open approach to collaboration and a practice which reflected interdisciplinary activities, each discipline identified issues of a uniquely professional nature which influenced their practice. OTs revealed that a general lack of understanding of the nature of their profession limited their interventions with potential clients. SLPs disclosed that funding ministries, particularly Education and Health, arbitrarily decided to fund SLP services according to the nature of the communication problem. This created gaps in service delivery with many children receiving no SLP service and others falling under the mandate of both Health and Education funded therapists. While both OTs and SLPs continued to adhere to their own individual goals, they considered these goals and their practice to be symbiotic and they acknowledged the cumulative benefit to the students they treated. Nonetheless, even when there was a strong commitment to interdisciplinary collaboration, a number of factors hindered the development of a close working relationship among even the most dedicated proponents. The barriers and facilitators to collaboration identified by the therapists will now be discussed.

Barriers and Facilitators to Collaboration

The therapists' experiences revealed a range of factors, which either facilitated or hindered the development of effective working partnerships. The widely varied experiences of therapists from different agencies and employment sectors facilitated the identification of factors, which influenced efforts to co-ordinate activities. Participants' dialogue revealed three thematic elements that influenced in their opinion, efforts to participate in collaborative activities with educational personnel and each other. These include the work environment, factors related to communication, and human resource elements. To facilitate the presentation, this information is presented first in table form, with facilitators listed in Table 2, and barriers in Table 3. A brief overview of these key elements will conclude the discussion.

TABLE 2
FACILITATORS TO COLLABORATION

Work Environment

Subthemes:

- Stable physical work environment
- Access to support personnel
- Proximity to other professionals
- Regular schedule
- Segregated classroom settings

Quotes:

"I've got an office, clients come to us for service.... We've got systems in place."
 "We have an assistant that can help us, so if I reserve the assistant then there's no problem."
 "I think the physical proximity helps as well and we share offices."
 "Luckily she's right across from me so it's in and out, in and out."
 "You have to gain their trust, you have to be there on the days you say you're going to be there."
 "In the segregated class we often do collaborate because we're often visiting at the same time."

Communication

Subthemes:

- Availability of on-site resources including comprehensive records
- Regular team meetings
- Communication technology

Quotes:

"There's the hospital chart so we know exactly what the other one is doing."
 "The child that has more medical complexity, we can go right to... clinic."
 "I think regular meetings and regular dialogue.... that's really a key part to being in touch with what is going on."
 "You can start to try and phone.... There are parents who do use cell phones."

Personnel/Personal Factors

Subthemes:

- Value of experience
- Consistency of personnel
- Individual motivation
- Acknowledgement of others' roles

Quotes:

"It changed with experience... the teachers felt my role was beneficial."
 "There's a lot of very, very stable staff... and there's something to be said for that."
 "I think just people who are open, who want to learn, who are very professional in what they do... have a strong sense of advocacy for their clients.... You know people have not been very territorial."
 "I need to consult with [other therapists]. I need to get and work with them in order to do my bit."

TABLE 3
BARRIERS TO COLLABORATION

Work Environment (primarily school-based therapists)

Subthemes:

- Travel, heavy, diverse, part-time schedules
- Difficulty coordinating schedules with others
- Large client caseload
- Lack of time
- Lack of human resources
- Multiple personnel
- Lack of encouragement by administrators
- Unfunded time for collaborative activities

Quotes:

"I had 30 schools at the beginning of the year... and I have about 65 students on my caseload."

"Time is a huge barrier... you have to depend on someone else's schedule meshing with your own."

"Everybody is always feeling very pressed for time!"

"If you don't hit it at quite the right time you're out of luck, it takes a while to find out what are the right times and who to talk to."

"People are either out in their car or driving around... it's not within your work hours."

"You're dealing with the teacher, the EA, sometimes more than one... then there's the vice-principal or resource teacher and then somehow you have to communicate with the parents."

"It's not encouraged either.... You would think that inservices would be given on how to work with [each other]."

"To phone the OT and have a chat, that we're not directly paid for."

Communication

Subthemes:

- Technological communication devices
- Lack of comprehensive health records
- Professional jargon

Quotes:

"It's the voicemail difficulties, the fax difficulties,... I think they're supposed to facilitate communication but it's not like getting the real person."

"It's like a nebulous place our technical world has given us."

"Access to background information is complicated."

"I had reports that were six or eight months past when the actual clinic was."

"We'll use words and expressions that people just don't understand."

Personnel/Personal Factors

Subthemes:

- Inconsistency and lack of experienced of personnel
- Lack of motivation on the part of individuals
- Lack of professional preparation

Quotes:

"It's hard on the team [when a member leaves], it sort of slows you down.... We have to readjust to that."

"There seems to be a lot of change of caseload in terms of when you try to find people."

"I feel like I'm in charge of the patient. We're not necessarily working on the same things."

"Some will call me back, some won't. Those that are just there to do their little job... won't call me back!"

"Either they just don't get it or they just really don't care."

"No, I don't think anything can prepare them for this [practice in schools]."

Work Environment: It Takes Time and Effort to Collaborate

The physical setting in which therapists worked was often cited as a significant element affecting their ability to collaborate. Therapists who were situated in one geographical site seemed to be at an advantage for inter and intra disciplinary collaboration. They remarked that their proximity and the frequency with which they came into contact with each other aided their communication and interaction. Pam noticed that proximity encouraged informal interdisciplinary communication. She explains: “You may not be the treating therapist but we're a small place so if you walk in the therapy area, you have a pretty good idea who they [the client] are or you talk to one of the other therapists and say, he needs [a certain treatment intervention].” Cynthia maintained an excellent relationship with a colleague in another discipline, the ease of which she attributed to geographic proximity: “She's very nice to work with, the doors are always open. Luckily she's right across from me, so it's in and out, in and out.” As mentioned previously, Heather maintained that sharing an office with co-workers facilitated dialogue, which in turn assisted integrated goals and treatment approaches.

Itinerant therapists on the other hand, were on the road travelling from school to school. Logistically they confirmed that organizing their own schedule was in itself a nightmare, and trying to co-ordinate activities with other therapists was next to impossible. Due to the numbers of clients located in schools spread all over the region, it was a challenge for each therapist to keep track of her own caseload. Angie's comments are representative of itinerant therapists' caseload: “I had 30 schools at the beginning of the year, I am probably down to 25 or so now, and I have about 65 students on my caseload.” Furthermore, as Angie noted previously, “some of them [clients] sort of fall through the cracks, I haven't seen them for some time!”

The work environment contributed to what the therapists identified was the greatest deterrents to collaboration, time factors. For the most part, each school therapist seemed to be following her own agenda and the co-ordination of schedules was too much effort and too difficult to orchestrate. "I think time, time is a huge barrier," offers Heather. "I mean it does take more time to work that way because you have to depend on someone else's schedule meshing with your own, and I think everybody is always feeling very pressed for time. So that certainly is a challenge, that's probably the biggest one." Emma describes what she sees is one of the biggest barriers to collaboration: "That's the biggest barrier, there's no time, ... because everybody's on their own agenda. They have their own schedule, everybody's run, run, run. You probably don't have much time to even talk ... you just want to do your thing and that's it."

To Erin, one of the greatest deterrents to collaboration was trying to co-ordinate everyone's schedule. She explains:

Biggest frustrations are resources and time and co-ordinating people, that's it. Because everyone's so busy, that sounds like such a simple answer, but it's, usually there'll be a teacher who has a class of at best 28 children to co-ordinate. There's other professionals who are managing caseloads, there's parents, usually both of them are working and even if they are working there's other kids at home to consider child care issues for, yea, there's a lot to coordinate.

Caroline who is situated in an agency, has experienced a great deal of frustration trying to contact therapists in the schools. She describes her efforts:

They're [school therapists] very busy too, try to get in touch with them On average you'll play telephone tag for days, like an average 4 or 5 days. They're busy, we're busy. We're busy after school when they're not busy. It's very difficult, they're not at one spot,

they're going all over the place ... If you don't have the name of the physio, you have to call the case manager It's easier for them because usually they have our card. It's easier for them to reach us, you're making me realize that there's a HUGE lack of communication!

Many therapists chose to work in school care because this type of employment accommodates a part-time flexible schedule, which fits well with family responsibilities. However part-time employment increases the difficulty of establishing contact with individuals in the community. Margot explains: "People work certain days of the week if they're not full time so if you're trying to access a part-time person, and you work full time [it is very difficult]." She adds that much important communication takes place after work hours, "If you really need to speak to a person in a certain time frame, it's being done in the evening."

Ideally Jesse claims that collaboration can only be achieved if therapists can arrange their schedules with that of others. "It works a lot better if all consultants can be in the same school on the same day because there's a lot of cross referencing," she explains. She adds, "The team only works if you're all in a school for a length of time, on the same day! Which sounds very ideal! And then you can't let anybody change it! Other than that, it's very difficult because you're on the road all the time."

In rare circumstances, predominantly in segregated settings where children with multiple disabilities are grouped in one classroom, efforts towards effective collaboration seem to be occurring. Angie describes how interdisciplinary goal setting was actually taking place in one of her school settings: "In the segregated class, often we do collaborate because we're often visiting at the same time. We do have twice a year meetings that are physio, OT, speech and the case manager and the teacher; we try to figure out goals in common for each student together."

Communication Including the Health Record

The physical means of communication including technology both facilitated and hindered communication. Annie acknowledged that electronic mail was, in principle, an effective contact tool, it could also be used as an effective deterrent. As she explained previously, “The principal and I have just been mailing back and forth but most of the emails come from my end, and I’ve had a few emails that were supposedly sent to me that I never got.” Margot found that technological advances such as voicemail and email only seemed to create frustration when she attempted to contact other rehabilitation therapists. She explains:

It’s like a nebulous place or person It’s the obstacles I think that our technological world has given us. It’s the voice mail difficulties, the fax difficulties, you don’t have a personal receptionist answering the phone where you can at least [leave a personal message] I really believe it’s not like getting the real person.

Therapists working in agencies where there were additional services located on-site, found this greatly aided effective communication. As Margot mentioned previously, she found especially with complex cases, it was a great asset to be able to contact other health providers directly.

Therapists felt that well structured opportunities to communicate such as regular team meetings were instrumental in facilitating mutual collaboration. “I think regular dialogue, and regular meetings to review different issues both related to the way we do our work, to different specific clients,” offers Kate. She adds, “So team meetings I think are a key part to it I mean it’s a pain on the one hand to go to a meeting and stuff like that. We meet right now, twice a month and at least about an hour to a little bit longer than that, but that’s a really a key part to being in touch with what’s going on.” Caroline describes a process, which in her experience was

a model of exemplary collaboration when a child was discharged from a health care agency. She outlines the scenario:

The school comes to the [agency] You sit with the physio, the OT, the doctor, the parents, the teacher, the school director, a bunch of people, speech, everyone is there.

Everyone is there and so you globally talk and then physio to physio you sit down after, then OT to OT you sit down after, perfect, perfect, perfect setting.

With regret she adds, “ Perfect setting, but that’s only when they’re discharged going back to the real world, and that’s it, [a] one shot deal.”

Therapists working in rehabilitation were under the impression that interdisciplinary collaboration among professionals was not encouraged by their employers. Emma reports:

It’s not encouraged either. You would think that in-services would be given on how to work with [each other], how to set your goals, or how to do an efficient therapy session, or how to consult in the classroom with the SLP. We could do some good work together.

Angie’s disillusionment with the system is evident, “Having a time that’s designated, and mandated to collaborate through the year, as a rule it’s not a focus of the system. So we get paid for our work with the client ... but to phone the OT and have a chat, that we’re not directly paid for. So that certainly is a barrier to communication.”

Having access to the student’s medical chart was an important factor in facilitating collaboration amongst health care providers. Caroline, who is geographically located on site in an agency, confirms that the medical chart is an essential tool that allows each therapist to know what the other is doing. She explains, “We share the chart so everything is in the same chart. There’s one chart for one patient. So there’s not the physio chart, there’s not the OT chart, there’s the hospital chart, so we know exactly what the other one is doing and that helps.” Pam claims

that working in one site and “having access to the health records” is an important factor that she highly values which aids collaborative activities and thus facilitates her practice.

Itinerant therapists on the other hand have a great deal of difficulty getting access to current medical reports and charts. Angie describes the situation:

The access to background information is complicated. Our referrals for a student may be two or three pages that basically says the concerns that the school has, and the concerns that the parent has, but access to a medical chart is next to impossible to get. We do get orthopaedic reports and seating clinic reports but I had reports that were six or eight months past when the actual clinic was.

She added that the process to obtain the chart was lengthy and inefficient, and was required to be co-ordinated through the case manager. She elaborates further:

We can ask our case manager to contact the facility for something but we can't go into the facility and ask for somebody's file But it's [the two page referral] not the same as having a nice folder to browse through and look at all the background. The past history of treatment too they'll leave out on, some of these kids have been for five or six years getting therapy and then they end up in our system, and we have two pages.

Jesse acknowledges that the lack of access to current medical files wastes time for therapists and potentially put the concerned child at risk. She expresses her concerns:

Everyone is afraid of the liability and who is ultimately responsible. I have no orders, that's another big problem is communication into the community. It's a major issue and it's a very big problem that we've tried to address. But we spend a lot of time trying to chase orders for our own liability. Here's this child who's had a lot of complications and major surgery, he returns to school and I have nothing in writing from the doctor ... I had

nothing in writing saying no restrictions. And the mother says, the doctor said he can do whatever he wants ... So I check my voicemail, I call the doctor, he's on vacation!

In addition to the communication related factors outlined above, several therapists raised the issue of language, or professional jargon, which could also hinder efforts to collaborate with both professionals and lay persons involved with the child. "Different jargon, that's one thing," cites Erin. She continues:

We'll use words and expressions that people just don't understand. Joint compressions is a really good example, because you can over do it They [teacher and EA] were thinking to compress the joint you really had to push. [They didn't realize] that it could be light, because they were thinking compressions, you press something, you hit it hard! There are words that we use so nonchalantly, because it's so much a part of our language, we don't think of the literal use of the language, how is the person going to interpret that. So the jargon's probably one of the biggest things.

Sally revealed that language was a major obstacle when she was developing a collaborative relationship with another professional. "We had to constantly define our own language because we do have different languages. I have a speciality language and she has a speciality language, and we might have similar words but we mean different things by those similar words." She went on to disclose that to reach a mutual understanding required a great deal of effort:

So that first year was a lot of work. Okay, you're saying that and I'm saying this, but what do you really mean? We have to constantly define an example. That was a lot of just patience, patience with each other. You had to give the perspective of your training and background, what does this mean when I use this word, what does that mean?

Personnel/Personal Factors

In addition to factors such as the therapists' work environment and communication factors, elements related to the personal attributes of the individuals themselves also facilitated or hindered collaborative interactions. Predominant themes emerging from the discourse included consistency of personnel and motivation to participate in collaborative activities.

Consistency of personnel was a factor that many therapists raised as being an important facilitator to collaboration. Pam feels that continuity of education and health personnel contributes to an ease and facility of communication. She explains: "There's a lot of that [informal communication] with very, very stable staff who have been here a very long time." Heather remarks that she has worked on a team that has been stable for a considerable period of time, and this has truly fostered effective collaboration. She adds:

For many years we would have sort of partners, like you were the SLP, you always worked with this OT on new clients that came in. So working with that person on that littler sub-team over the year with various clients, you got a real feel for how the other person worked. You could plan together, we write reports together, a lot of the work is really done together, so I think it has evolved because it's such a close collaborative.

A substantial background of common experiences contributes towards the development of trust and cohesion in Jesse's point of view: "I think because this team has worked together, consistency has a lot to do with it, knowledge of the child, knowledge of the home situation. You become a team through long term involvement." Kate on the other hand has experienced a stable team, which has recently undergone significant changeover which she feels is a real detriment to collaboration. She describes how this has impacted on her practice:

It is a problem, it really is. Because you get to know the style of a person and whoever's working with them. What they need, how much time they need to do something, and then we have to sort of readjust to that [when that person changes] It's hard on the team, it sort of slows you down, because of the work that you're doing. You know if we're missing SLPs, or OTs and technologists, things just certainly don't happen at the regular pace and so it puts more stress on the team and certainly clients are calling, wondering where things are at.

In Angie's experience, just the number of different people that she has to collaborate with is a huge obstacle to co-ordinating goals and treatment. She elaborates:

Because among the 30 schools I have, I work probably with eight or nine different OTs. In this system, I have a whole bunch of different people that I work with. In most caseloads each OT probably has 50 or 70 students to see, they are at all kinds of different schools, they have meetings, time restraints, geographical constraints that sort of thing.

Therapists working in agencies who collaborate with school-based therapists find a general lack of consistency among these therapists a significant challenge. Margot describes the difficulties she has encountered:

A number of changes of therapist, like from one year to the next the same child won't necessarily have the same OT or same physio There seems to be a lot of change of caseload ... Every year it is a change, so maybe one therapist might have done a group of schools and then things were changed around because of the nature of the demands. I think in the interest of the community, maybe that therapist would have gotten to know that school, that group of kids, and then there's a shift around ... it is hard to keep track of where therapists go.

Motivation on the part of individual therapists to make an effort to collaborate with one another was cited by many participants as a factor influencing collaboration. Heather felt that willingness and openness to collaborate had to start with individuals themselves. She elaborates further on the type of personality she feels makes a team player :

I think people who are open, who want to learn, who are very professional in what they do. They're there for the clients, have a strong sense of advocacy for their clients and putting the client first. I think that most of the people that I deal with, we all seem to really enjoy what we do as a profession. So I think that just lends itself to being open to new ideas and learning.

Several therapists reported they felt that the lack of motivation on the part of individual therapists to collaborate was a major deterrent to mutually co-ordinated activities. In Emma's opinion, overwhelming caseload responsibilities diminished the therapists' energy, time, and incentive to collaborate. She explains:

There's also a lack of willingness I think [on the part of] the therapists. You know when you're in a hospital, well everybody's there, it's easy. When you're working in the community like this, and you're making your own schedule, and you have visits that you have to do. You know, you're rushed, rushed, rushed; there's not much time. [It] takes a big effort to take a couple of minutes and say, okay, I'm going to meet the OT. We're going to sit down, we're going to discuss a good plan. It would be much more efficient.

Therapists reported that there seemed to be a general lack of interest on the part of some therapists to participate in collaborative activities with others. Emma was very frustrated with her inability to contact other therapists. She recounts her experiences:

I'll leave a message for the speech [language pathologist] and I'll just say, this is what I'm doing, or this is where the child is at fine motor wise. Or I'll call and ask for a suggestion, what are you doing in speech, that I can do in my session? Very difficult, I find I'm often the initiator when it comes to that. Some will call me back, some won't. Those that are just there to do their own little job, and don't want anything to do with anybody else, won't call me back!

Heather, as well, has encountered a number of therapists who seemed to have little interest in collaborating with others. She describes her experiences further:

I've worked with some individuals in the school setting, who are wonderful. They want to do whatever you can give them to do because they really want to see this child move forward. I have others who would just, they just don't get it. Either they just don't get it or they just really don't care. They just want to go in, do what they officially need to do, and then I'm coming from a different agency, and there's no official reason why we really need to work together other than the good will of the people involved and their desire to help the child. We don't report to the same people, I don't report to the school board and they don't report to my agency. So there's no formal channel for that, and so I think it comes down to just who is interested or not.

Recognition of the essential role of other disciplines was an important factor that motivated therapists to collaborate. Heather explained that to achieve her particular goals she required the expertise of other disciplines. She elaborated further:

I'll get a client, let's say I have to put a communication system into place. Well this client can't move any part of their body, I'm not the expert in movement, so how are we going to do this. I mean I need to consult with [other therapists] and work with them in order to

do my bit. So I think part of it is a necessity just the sort of work that we do lends itself very well to working as a team because you have to.

In summary, therapists identified a number of factors that facilitated or hindered effective collaboration with educational personnel and each other. Issues such as multiple work sites, lack of sufficient time, and heavy and demanding schedules were identified as major deterrents to effective collaboration. Ease of communication, access to relevant documentation and personal motivation were also acknowledged as important factors in developing meaningful partnerships. Finally stability and consistency of personnel, professional jargon, and employment agency support were additional factors which played an important role in facilitating or deterring effective and meaningful partnerships.

Chapter Summary

The discussion in this chapter highlighted issues related to professional values, beliefs, rewards, and frustrations that therapists identified within the context of their daily work. Surprisingly, in most cases the therapists' perspectives were more closely aligned with colleagues working in similar employment sectors rather than with their disciplinary counterparts.

Therapists, depending upon their employment context, expressed very differing views related to agency initiatives to support their professional practice. Therapists in public sector organizations revealed there was a very strong infrastructure in place to promote personal and professional development. Office space, ready access to therapeutic materials, and having access to a multi-disciplinary team, permitted therapists to be more efficient and effective in their

professional roles. They were highly appreciative of the support provided by their agency to enhance their professional knowledge and skills.

School-based therapists on the other hand, felt totally isolated within their professional environment. They acknowledged the lack of colleague support and they resented the number of essential tasks they were required to fulfil during their own unpaid time. An issue of major discontent was the total absence of assistance from their employer for professional development activities. Private based therapists acknowledged the solitary aspects of their practice, however they had developed their own informal supportive infrastructure of colleagues to sustain them within this isolated context. Private therapists acknowledged that their personal skills were essential to being marketable, and thus participated frequently and willingly in continuing education activities at their own expense.

Professional autonomy was a contentious issue with therapists. Therapists working in schools expressed extreme frustration with their enforced consultative role. They resented the control of their professional autonomy by agency mandates and personnel, and felt they were compromising their professional values and the service they were obliged to deliver to clients. They were thus highly disillusioned with their profession and what it had become. Private and public health based therapists on the other hand, highly valued the professional autonomy they experienced. They cherished the respect they felt they had earned, and were proud of their freedom to determine client goals and interventions according to their professional judgement.

Inquiry into collaborative initiatives was truly disappointing. While in principle therapists acknowledged a willingness to collaborate, in practice, true, effective communication and interactivity was very rarely taking place. Some disciplinary characteristics were noted. OTs and SLPs expressed a more open and receptive attitude to collaboration and their discourse revealed

that in selected cases, partnerships between these two disciplines were actually taking place. PTs on the other hand, tended to be more resistant and less motivated to participate in collaborative activities among themselves and other disciplines. OTs acknowledged that a general lack of awareness of the nature of occupational therapy limited their potential effectiveness with clients. Finally, SLPs reported fissures in ministry funding patterns, which either restricted their intervention with clients, permitted some children to receive treatment by two therapists, and/or left some needy students completely void of the services of an SLP.

The therapists acknowledged that in large part the ability to work effectively with educational personnel and other therapists was beyond their control. Unrealistically heavy schedules, insufficient time, multiple work sites which included travel time, all contributed to their ineffective coordination with others and their lack of motivation to do so. Additional factors such as timely access to comprehensive medical records, professional jargon, and inconsistencies in personnel were other factors inhibiting the development of meaningful working partnerships. In short, it was the therapists' overall impression that while intra and interdisciplinary collaboration was a goal to be aspired to, in the present school and health environment, it was practically an unrealistic impossibility.

CHAPTER 8: DISCUSSION: VOICES OF THE THERAPISTS FRAMED WITHIN THE LITERATURE

The purpose of this qualitative study was to examine the everyday work lives of therapists who deliver services to children with physical disabilities educated in inclusive schools. The intent was to explore the complexities of their practice along with the personal and professional dilemmas they encounter in order to better understand the challenges they face, in light of on-going change to both health and education services. The previous three chapters have addressed the three research questions and described in the therapists' own words many of the issues they identified which impacted upon their daily practice. The purpose of the present chapter is to consider these findings in light of the relevant scholarly literature. This discussion indicates where findings from this study provide support for existing literature, where, in fact gaps have been identified and deserve further investigation, or where inconsistencies exist and previous assumptions are challenged. This discussion is organized according to the three research questions and themes previously presented, namely collaborative partnerships; therapy services in the inclusive paradigm; and professional issues. Each topic will be discussed in turn, synthesizing the findings from this study and relating them to the existing academic literature.

Forging Collaborative Educational Partnerships

The first research question addressed in this study asks, "How do therapists describe the collaboration they experience delivering services in inclusive settings?" This study focuses on the notion of school-agency partnerships, suggested to be an effective means of coordinating the collective activity of parents, teachers, and other professionals to foster optimal development of children in home, school, and community settings (Corbett, Wilson, & Webb, 1996). According

to Smrekar and Mawhinney (1999), schools are the most appropriate locus from which to coordinate services for, "Schools provide the organizational context for the most sustained and ongoing contact with children outside the family setting. This unique position can be utilized to establish a process of problem identification and treatment" (p. 444). The public responsibility for the investment in youth is viewed as a social necessity, "to sustain the nation's economic growth, productivity, and technological development" (Crowson and Boyd, 1993, p. 145). In the province of Ontario, this commitment, based on a school/agency partnership model, is clearly articulated in the vision of the Ontario Ministry of Education for Special Education which states:

The goals are to provide the best quality public education system for Ontario's children and ensure that the education system equips them for lifelong learning in a rapidly changing and competitive world. The Ministry of Education will also work with parents, other Ontario government ministries, and education partners to improve the coordination of services (for example, social, health, speech-language, and psychological services) for students with special needs. (Ontario Ministry of Education, 2001, p. 1).

The present study provides an opportunity to examine how the model of school/agency partnerships for rehabilitation services, as suggested by the Ministry objectives above, is playing out for children with exceptionalities in inclusive school settings.

For children with physical disabilities to achieve their academic and social potential, some researchers recommend that the services provided by SLPs, OTs, and PTs should be an integral part of the school environment (King et al., 1998; Wolery & McWilliam, 1998). They go even further to suggest that instead of providing traditional direct, hands-on treatment, therapists should serve primarily as consultants working collaboratively with educational personnel and parents who are in turn responsible for applying the required therapy (Case-Smith & Cable,

1995; McEwen & Shelden, 1995). This collaborative approach to therapy delivery has been described as the preferred service model in inclusive educational settings (Case-Smith & Cable; Giangreco, 1995; McWilliam & Sekerak, 1995). For collaboration to work effectively, McWilliam and Sekerak suggest there must be: “an assumption of equal power between the classroom teacher and the specialist, where each recognizes the experience and expertise of the other” (p. 51). Effective collaboration and delegation of roles implies the development of trust and the existence of competent, willing individuals who have the time, motivation, and skills to assume these responsibilities. The findings from this study suggest that while school/agency partnerships and the consultative model of therapy service delivery are sound in principle, many factors, within a context of multiple pressures and demands, can limit the effectiveness of this proposed approach.

The Foreign School Environment in Which the Principal Sets the Tone

In the present study, therapists working directly in schools identified a school personality or culture, which created an attitude towards their intervention and effectiveness. They acknowledged that no matter how long they had been associated with a particular setting, they were always considered “guests” or “outsiders” within the foreign school environment. In Jesse’s case for example, even though she was situated in the same school, following the same weekly schedule over a period of several years, she never felt truly a part of that academic unit. She was always made to feel like an intruder in the staff room, and was never included in any school-wide social activities, an indication, she felt, of her continued outsider status.

Hoy and Miskel (2001) describe organizational culture, in relation to schools, as the common goals and values, which unite an agency and give it its own particular personality. Therapists and educational personnel are derived from two very distinct professional cultures.

Even though they work physically in the same environment, they maintain their closest alignment with colleagues of the same discipline (Beattie, 1995), and the intensity of the school environment provides few opportunities to bridge the gaps to forge working partnerships.

In their discussion of schools as cultures, Firestone and Seashore Louis (1999) utilize Schein's (1992) interpretation of school culture as, "basic assumptions that the group learned as it solved its problems of external adaptation and internal adaptation" (p. 298). They discuss distinct levels of school culture ranging from superficial and openly apparent factors such as language, to "deeply embedded basic assumptions which are difficult if not impossible to articulate" (p. 298). Participants in this study recounted examples of both explicit and subtle manifestations of the existing cultures in the schools they visited. Therapists such as Angie and Emma described the visible reflection of school "personality" when support staff completely ignored them as they entered into the setting, or educational personnel demonstrated little interest in being involved in therapy delivery. On the other hand Annie's continuing struggle to find appropriate space and Cynthia's description of a principal who was "politically very correct" and did not see children with special needs as being "a priority" were manifestations of embedded cultural belief systems that maintained therapists as intruders.

According to Firestone and Seashore Louis (1999), the proposal that school culture is developed, molded, and directed by the school's leadership, the principal, was supported by therapists in this study. Holly stated very clearly it was her impression that the principal set the rules concerning therapists' activities and relationships within the school setting. Annie was of a similar opinion that therapists' degree of acceptance or rejection was influenced by directives from the principal. Acknowledging this essential role, Emma recounted how she always sought

the counsel and permission of the principal prior to entering into negotiations directly with teachers.

School culture is furthermore heavily embedded with the concept of control (Gardner, 1993; Smylie et al., 1996). As schools exist in highly unstable environments, it is the principal's role to buffer the organization from outside threats and set what he or she feels are guidelines for realistic expectations from outsiders such as parents, community workers, and therapists (Smylie et al.). The study by Smylie and colleagues describes how principals kept community workers, who were perceived as potential threats to the status quo, at a distance by ignoring their repeated contact efforts. Annie told of similar tactics from a principal who did not respond to her emails and calls as he did not want to get involved in what she felt was a politically charged issue. Both Holly and Marie were exposed to more direct strategies when principals openly rejected and/or criticized their efforts. Many therapists reported their overtures to collaboration were frequently met by defensiveness, procrastination, and avoidance; behaviours all well documented to be typical methods to deter and reject outsiders (Gardner, 1993; Smrekar, 1993; Smrekar & Mawhinney, 1999).

The only study which makes explicit reference to the educational milieu as a foreign environment for therapists is that by Niehues et al., 1991. In this report of occupational therapists in public schools, participants claimed they felt "both personally and professionally unknown" (p. 204) in the school environment and frequently they perceived themselves as disruptive rather than complementary to the classroom setting. This feeling of alienation could also have been compounded by another factor acknowledged by therapists in the Niehues et al. study, that of the lack of clarity related to the profession of OT, findings also supported in this present study. The reports of therapists such as Holly and Angie, are consistent with the views expressed by

Niehues et al. Holly's claim that she felt she was more of a nuisance rather than an assistance in the classroom, was supported by both Angie and Sally who remarked that they felt uncomfortable asking already overworked teachers to apply therapy. Emma's firm impression, as stated previously, that she was "always a guest" in the foreign educational environment, was consistent with the view of all school centered therapists. Several OTs also supported the claim that the scope of their discipline is still not fully understood by parents and educational personnel.

In sum, the present study adds support to the existing literature and provides compelling evidence that within an Ontario context, therapists may frequently perceive the school setting as a hostile and foreign environment to outsiders. The therapists' feelings of rejection by principals and school personnel and that they were always considered guests in the school setting is supported by studies documenting the poor success of school-community initiatives more generally (Smylie et al., 1996; White & Wehlage, 1995). The discussion thus far, reconfirms the findings of previous reports, which highlight schools as foreign, controlling environments. The discussion to follow, however, which examines the nature of collaborative partnerships in the school setting, demonstrates inconsistencies with previously documented theories and findings.

Collaboration with Teachers

In the present study, according to itinerant therapists working directly within school settings, meaningful collaboration with teachers was far from the ideal proposed in the literature. Their stories exposed an environment laden with tensions related to multiple and complex expectations, within a restrained and highly pressured infrastructure. It was the therapists' impression that teachers felt unprepared to meet the challenges of inclusion of children with disabilities into their classrooms, findings similarly documented by Scruggs and Masterpieri

(1996) in a review report of teachers' opinions of inclusion. On the one hand, therapists felt their suggestions and interventions were welcomed by teachers who felt overwhelmed by the challenges they encountered in the diversity and complexity of the student population in their classrooms. At the same time, however, therapists reported they perceived themselves to be disruptions rather than facilitators to classroom activities, consistent as reported earlier, with the findings of Niehues et al. (1991) with public school OTs. This contradictory role of therapists serving as both valuable resources and disruptive distractions can perhaps be explained by the incredible burden the 'regular' activities of the general classroom are placing on teachers. Therapists revealed that teachers seemed overwhelmed by their changing roles encompassing demands of the academic curriculum, large class sizes, extracurricular responsibilities, and the individual demands of children from many cultures with widely disparate specialized needs. All these issues have been documented in an extensive review of teachers' impressions of mainstreaming/inclusion by Scruggs and Mastropieri (1996).

It was the therapists' impressions that the lack of sufficient time in both the teachers' and therapists' daily schedules was a major factor in preventing the development of partnerships. Therapists reported that teachers had virtually no available opportunities to meet to discuss specific cases, let alone develop working and trusting relationships, a recommended necessary pre-requisite to effective collaboration. Given what is known about teachers' lives, perhaps teachers also had little interest in receiving therapists into their classrooms. Lortie (1975) in his classic sociological study of teachers affirmed even at that time, that teachers' primary allegiance is to teaching and classroom activities. All individuals associated with other functions were described as, "intruders ... connected with undesirable occurrences" (Lortie, p.169). School-based

therapists also had large numbers of children on their caseload, spread out over a broad geographical region, a factor, which also hindered opportunities for collaborative activity.

A study by Kemmis and Dunn (1996) reported that while successful collaboration between teachers and OTs improved collaborative goal setting and student outcomes, the time required to accomplish this objective was at least a one-hour meeting per week. The findings of the present study suggest that in the working lives of both therapists and teachers, the time requirements for building successful partnerships is highly unrealistic within their heavily scheduled agendas. In effect, neither culture contributes to the development of effective partnerships. While the notion of therapists serving as consultants to teachers, working closely to harmonize academic and therapeutic goals may appear to hold promise in principle, it appears highly improbable within the context of the educational environment of this study. In fact, according to the therapists interviewed, for the most part meaningful collaboration is just not happening.

Collaboration with Educational Assistants (EAs)

In the present study, school therapists reported that educational assistants (EAs) played a major role as prime deliverers of delegated therapy. Despite the conviction that EAs play one of the pivotal roles in therapy delivery, the scholarly literature is remarkably silent on this issue. More specifically, a search of the literature revealed few studies that focus directly on the role of the EA and the impact of delegation of therapeutic activities on the children in their care. One exception is Kellegrew and Allen (1996) which made reference to the role of the EA in a case study examining the integration of a child with special needs into a general classroom. Similarly Rivers and Griffith (1995), in examining the level of bureaucratic processes which take place when a child is integrated into the regular classroom, described the role of special education

“paraprofessionals” who limited the child with special needs from developing his/her independence and autonomy. Danks (1990) in a questionnaire study of teachers, parents, and EAs on their impressions of inclusion, reported that EAs felt they received minimal if any specific training on how to deal with children with special needs. Hehir (2002), in a discussion of ableism or “the devaluation of disability” (p.1), recounts the case of an aide who served as a buffer, preventing the child from participating directly in class activities. For the most part however, the majority of research reports in the literature includes references only to teachers and therapists; there is a noticeable absence of acknowledgement or examination of the role of the EA (Campbell, 1987; Giangreco, 1995; Rourke, 1996; Wolery & McWilliam, 1998).

One school board for example, describes the role of the teacher/educational assistant (EA) as a support worker to classroom activities, assisting children with special needs such as “developmentally delayed, physically handicapped, deaf, blind, or experiencing behaviour/social/medical problems” (Ottawa-Carleton Catholic School Board, 2002). The role of EAs differ according to the specific needs of individual students. A recent notice advertising the availability of positions, outlined the following qualifications for an EA: “The ideal candidate will have: post secondary studies in a related field (i.e. Child & Youth Worker, Early Childhood Education, Developmental Service Worker, braille, signing, Behaviour Technology); one year of practical experience working with special needs children” (Ottawa-Carleton Catholic School Board, p.1). While the ideal EA may have some post-secondary training, therapists in this study revealed that the majority of EAs they were in contact with, had minimal formal training, and learned their skills primarily on the job.

The findings from this study reveal that while EAs are responsible for carrying out delegated therapy activities, they have limited time and minimal formal training to support them

in this essential role. School-based therapists reported that it is actually the EAs who are responsible, for the most part, for delivering the therapeutic programs to children with disabilities in inclusive schools, albeit in a greatly limited fashion. Once the therapists determine the therapy goals and program, it is the EA who is expected to carry out activities such as standing and walking (Cynthia), general mobility (Jesse), communication practice (Annie, Marie) and stretchings (Angie). While these therapists acknowledged the critical role played by EAs in the management of children with special needs, it was their impression that the downloading of professional responsibilities to untrained personnel, who also have very limited available time, is having a significant negative impact on the quality and quantity of therapy received by these children. Cynthia and Caroline reported how they had seen children cease independent walking because of the lack of supervised practice, while both Erin and Angie reported injuries to children when EAs inappropriately applied assigned therapy techniques.

Cuts in the total number of EAs, lack of consistency in support personnel, and diminished priority status for therapeutic programming vis à vis other activities, are forcing therapists to severely limit their goals and recommendations for intervention. Jesse wonders to herself if it is worth her time and effort to write reports and develop even such limited programs. Therapists confirmed that therapy programs are delivered sporadically, if at all by EAs, and the lack of prerequisite skills and knowledge in the EAs' repertoire has been reported, as revealed by Angie and Cynthia above, to be either ineffectual or even deleterious to the child's health status. Therapists such as Emma and Annie report that the number of EAs has been greatly reduced. EAs' priorities within the classroom are related to academic, social, and hygienic needs such as feeding and toileting which take precedence over therapy for the limited available time. There are also few opportunities for consultation with EAs, which limits required follow-up and

supervision of delegated programming. The end result, according to therapists, is that children with physical disabilities are not receiving the quality and quantity of therapy they require. Many youngsters fail to progress, and worse still, others are showing signs of deterioration and regression of previously attained skills. Further study is urgently needed to systematically examine the impact on children of delegation of therapy responsibilities to EAs.

Education/rehabilitation Teamwork

The reflections of therapists from different work settings and environments provide insight into the functioning of education/rehabilitation teams. Teamwork is defined by Rainforth and York-Barr (1997), using a 1987 Webster's definition as, "work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole" (p.17). Teamwork implies collaboration amongst team members described as "an interactive process in which individuals with varied life perspectives and experiences join together in the spirit of willingness to share resources, responsibility, and rewards in creating inclusive and effective educational programs and environments for students with unique learning capacities and needs"(Rainforth & York-Barr, p.18).

McWilliams and Sekerak (1995) describe three models of teamwork in educational settings. These include the multidisciplinary team model where members, while being cognizant of the roles of other disciplines, do not participate in role or information sharing. In the interdisciplinary team model on the other hand, the various professional team members work in isolation carrying out their discipline specific roles, however information is shared amongst team members. The transdisciplinary team model suggests an integrated and collaborative working style of members who address each child's specialized needs by sharing both information and

roles, the model endorsed by many researchers such as Case-Smith and Cable (1995), Giangreco (1995), McWilliam and Sekerak.

The ideal model of professional collaboration in inclusive educational settings, according to Rainforth and York-Barr (1997), is the transdisciplinary team model based on the underlying premise that the needs of children with multiple exceptionalities are inter-related. This teamwork paradigm is characterized by the feature of “role release” in which the knowledge and practices traditionally affiliated with one specific profession are transferred as needed to other members of the transdisciplinary team. Traditional disciplinary, curative medical model approaches are felt to be inappropriate and ineffectual in order to equip children with exceptionalities to meet the multiple and complex demands of their natural educational and social settings.

This background on teamwork models provides insight into the actions and comments revealed by therapists in this study. While they purport to be members of an interdisciplinary team, the school-based therapists continue to hold fast to the multidisciplinary model described above. Both Holly and Angie described student case conferences where they would meet the other “team” members for the first time, discuss their own professional role with that child, and then continue to work in an isolated manner sharing neither information or skills, a model sharply contrasting the ideal transdisciplinary concept described above. Emma confirmed quite emphatically that therapists were strictly involved in their own disciplinary goal setting. Holding firm to this traditional model of isolated disciplinary practice continues to perpetuate the status quo and inhibits the movement to more collaborative integrated models of practice.

The public health and public education therapists demonstrated a much more open approach to collaborative practice, which characterizes most closely the interdisciplinary model of teamwork described by McWilliams and Sekerak (1995). Both Heather and Pam described

how working in close proximity to other disciplines facilitated the sharing of client-related information. Cynthia related how having an office close to her OT colleague permitted the on-going back and forth exchange of important information related to client performance and changing needs.

Private therapists also demonstrated characteristics of an interdisciplinary model of teamwork. Nicole described how she was involved in working with educational personnel in setting students' educational goals. Carol revealed that in her experience therapists of different disciplines tried to work together, reinforcing each other's role and sharing client and treatment information.

In short, the practice described by therapists in all work settings falls short of the idealized goal of transdisciplinary practice advocated in the literature. Therapists in private as well as public health and public education settings were more inclined to demonstrate trends of interdisciplinary team practice. Regrettably however, the school-based therapists were more firmly entrenched in patterns of isolated disciplinary activity. Factors such as the highly strained educational environment, firmly engrained traditional patterns of disciplinary practice, and a lack of motivation to entertain new and innovative models of service delivery could all have contributed to these findings.

Collaboration with Parents

Throughout the scholarly literature, experts acknowledge the essential role of parents as partners in directing the care and programming for their children with special needs (Crowson & Boyd, 1993; King, et al. 2000a; Smrekar, 1993). Rosenbaum et al. (1998) in advocating "family-centered service" (p. 5) assert that "the family is the constant in a child's life", and "parents know their children best and want the best for their children" (p. 5); they thus should be the key

players in collaborative partnerships involving their child. King, et al. (2000b) add that family-centered service delivery is more effective and cost efficient. Smrekar (1993) maintains that in a child's life the family should be considered center within an ecological perspective, existing within "cultural, economic, and geographical communities" which are "separate spheres with blurry boundaries" (p. 176). A recent survey (King, et al. 2000b) of parents of children with physical disabilities and service providers regarding their perspectives of family-centered service indicated both groups fully supported this philosophy and believed strongly in the role of parents to direct the management of their children's therapeutic programming.

It was surprising therefore, to hear how infrequently the school-based therapists generally acknowledged the critical role of parents and their importance as integral members of the therapy team. For the most part, when speaking about this issue, therapists considered parents just one more group of individuals to deal with instead of being valued as key players in the care of their child. Most school-based therapists reported parents seemed indifferent to the therapy, which was taking place, regardless of the severity of their child's condition. There was a sense that the responsibility for therapy and associated activities had been delegated to the school, and perhaps, due in part to the very sporadic nature of the therapy delivery, parents did not consider therapy would have any serious impact on their children, therefore why become involved? Therapists did acknowledge however, the tremendous burden suffered by these parents in terms of time, energy, and finances caring for their child.

Therapists claimed they attempted to initiate parent contact by note writing and telephone calls, however both Angie and Holly rationalized that indifference on the part of parents they observed, was most probably due in large part to their heavy work schedules and the demands of other siblings. Sally on the other hand was very frustrated when parents couldn't be bothered to

get up in time to send their child to specialized therapy programs. Both Jesse and Angie were annoyed by parents' lack of interest in therapy goals and programming, and in general their overall indifference regarding the child's therapy. It must be noted, however, that therapists' efforts to contact parents may have been curtailed by the absence of financial compensation for phone calls, and a general lack of motivation on the part of these providers.

In the present study, the lack of communication between parents and school-based therapists is understandable in light of Smrekar's (1993) findings that effective communication between families and school personnel must be founded on "trust, familiarity, and understanding" (p. 182). She asserts that if organizational processes do not support these values, lines of communication will be ineffectual or even nonexistent. In this study, neither the school nor the therapy infrastructure supported the development of effective relationships with parents. According to the school-based therapists, the educational institutions where they worked are under severe tension due to scarce human and physical resources. The lack of consistency and continuous change-over in therapists revealed by Catherine and Margot, and the lack of financial support for telephone contacts reported by Emma and Angie, do not facilitate the development of familiarity and trust required for effective partnerships. It would appear that unless therapists are encouraged and supported in their efforts to establish regular contact with parents, the latter will continue to feel alienated and apart from what takes place in the classroom.

In sharp contrast to the school therapists, the stories of health agency and private participants depict parents as proactive and committed. These therapists reveal that parents actually seek additional therapy for their children, they initiate the contact, and they also make the effort to take their children to therapy sessions. Health care agency therapists expressed unsolicited concern and support for not only the child with disabilities, but also their family; they

prided themselves in offering a family oriented service. Both Margot and Pam, for example, revealed they felt their role, in addition to providing therapy to the child, was to help the family accommodate to the child's disability. Heather indicated that her treatment focus was directed at parents, as they were the prime source of encouragement and consistency for their child's communication skills. These findings are in keeping with the views expressed by service providers in support of family-centered care (King et al., 2000b). It appeared that repeated direct contact with therapists over an extended period of time, in contrast to the school therapists described previously, facilitated the development of familiarity and trust. Parental commitment in terms of transporting the child to therapy and taking responsibility for carrying out the therapy programs at home also helped promote the development of effective parent/therapist partnerships. The existence of a strong health agency infrastructure consisting of an acknowledged family-centered philosophy and interdisciplinary teams of personnel whose interventions modeled this approach, served to reinforce a family oriented organizational philosophy throughout client/therapist activities. M. Law et al. (2001) reported that service providers were more inclined to demonstrate a family-centered focus when the resources and infrastructure were in place to support this approach. Clearly this was not the case in the school-based settings examined in this study.

Private therapists, while they did not espouse a family-centered philosophy per se, did report that parents supported therapy goals and could be relied upon to carry out treatment interventions, primarily because they are paying for this service. Private therapists such as Nicole and Erin indicated that because parents had actively solicited their services and were willing to pay out of their own pocket, parents were committed to collaborating with therapy activities. Understandably parents who actively seek out the services of a rehabilitation provider;

communicate with therapists regularly, frequently receiving them into their home; and in many cases pay directly for their services, were more likely to comply with treatment follow-up. It appeared this consistent and regular contact between both parties facilitated the mutual development of trust and commitment and helped forge effective partnerships. Schreiber, Effgen, and Palisano (1995) in a study examining parental support with therapist designed programs versus programs reflecting a parent collaborative focus, found both parent groups demonstrated remarkably high levels (77.5% to 80.3%) of compliance with a 6-week home program. The authors suggested that strongly motivated parents in both groups could have contributed in part to these findings. They also proposed that as the socioeconomic status of parents increases, “parents are more likely to devote energy and attention to a home program or other recommendations from professionals” (p. 62). Both these factors, that is parental motivation and sound socioeconomic status, very likely played a part in the parental support reported by private therapists.

In summary, the findings of this study raise serious concerns about the recommendations of experts who advise that in inclusive classrooms, therapists divest themselves of their direct treatment role and serve only as consultants to educational personnel who are then responsible for integrating therapy regimes into classroom experiences. While the therapists in direct school practice have been mandated to serve only as consultants, the implementation of this mandate within the current social and economic context is proving problematic. In response to the first research question related to collaboration between therapists, educational personnel, and others, according to participants, in today’s school environment there appears to be neither the time nor the motivation to build meaningful professional relationships. In consequence, there is minimal collaborative goal setting and integration of therapeutic activities into classroom and home

activities. In effect, each member of the education/therapeutic team (if in fact it is even appropriate to refer to a team) has barely sufficient time to address their own multiple and diverse responsibilities. As a result, children with physical disabilities in these inclusive settings are receiving minimal if any therapeutic programming, and therapists have noted children whose conditions are either failing to progress, or even deteriorating due to the lack of appropriate intervention.

Therapists working directly in schools reported similar findings with respect to collaboration with parents. As both therapists and parents are, in effect, outsiders in relation to the school environment it is hardly surprising that little meaningful communication exists between these two marginalized groups. On the other hand, health care agency therapists working within their own organizational infrastructure which values a family-centered philosophy, reported strong collaborative ties with parents. Private practice therapists also confirmed similar findings. It appears that parental initiatives to organize therapy, their motivation in terms of the benefits of treatment, and their commitment to on-going communication with therapists are key factors responsible for building successful partnerships in the therapeutic relationship.

The Inclusive Experience and Therapy Service Delivery Models

Therapists' Views of the Impact of the Inclusive Paradigm

Although this study did not set out to examine the impact of inclusion on children with physical disabilities directly, the therapists' comments and observations offer a unique perspective of the impact of the inclusive paradigm on children with specialized needs, whose parents cannot afford private care. Furthermore, situating this study within the expectations and

demands of the inclusive education model is necessary for the reader to grasp the tensions and pressures for therapists as they deliver their services in this complex environment. It must be remembered that these findings represent solely the viewpoints and impressions of therapists, derived from their personal observations and interactions with the children they serviced. And while these observations offer insights into the nature of the inclusive experience, there is no attempt to evaluate the impact of inclusion on children with specialized needs over the short or long term. The second research question addressed by this study examines how the therapists perceived their practice was affected by the inclusion education model.

Consistent with the views expressed by Lupart (2000) advocating the benefits of the inclusive education model, in the region where this study was conducted, children with exceptionalities are being increasingly educated in regular classroom settings, with inclusion being the preferred educational model regardless of the child's physical or intellectual limitations. Angie and Jesse's stories of younger children and those with purely physical disabilities being, they felt, most effectively integrated into all classroom activities are supported in the findings of Center, Ward, and Ferguson (1991), and Scruggs and Mastropieri (1996). These studies report that youngsters in the early grades, children with minimal levels of intellectual impairment, and those with physical disabilities were the most likely to experience success when mainstreamed within the regular system. According to the literature, the degree of success of the inclusive experience seems to be associated with the severity of the child's disability, that is, the less severe, the greater the potential for success.

For the most part, however, the therapists' observations do not concur with the views of advocates who predict widespread social and academic benefits of inclusion (Brown, 1997; Forlin, et al., 1996; Fuchs & Fuchs, 1998; Jenkinson, 1998). Participants' comments provide

further support to several studies which reveal that children with disabilities were indeed, not being completely integrated into the social fabric of their schools. The therapists' observations lend further confirmation of the findings of Heiman and Margalit (1998) who reported increased feelings of loneliness and depression in exceptional students mainstreamed within regular schools. The stories of Jesse's and Catherine's clients who stated they had no friends and were rejected from cooperative activities with their classmates, are in keeping with the conclusions of Llewellyn (1998) who stated: "Mainstream schools merely heightened their [the children with disabilities] social isolation and loneliness.... There appeared to be little evidence of spontaneous mixing between physically disabled young people in mainstream schools and their able-bodied peers." (p. 740). It appears that the attitudes of rejection and hostility reported by Ferguson (1997) in regular middle and high school students, are consistent with the attitudes many therapists saw demonstrated towards the students they visited. It must be cautioned, however, that perhaps therapists chose to recount more selectively the experiences of children who stood out from their peers rather than relate the stories of those who were included in school activities. The factors contributing to peer integration and rejection are issues requiring further urgent study.

While inclusion is reported to increase 'normal' social interaction, and facilitate the development of autonomy and independence in children with special needs, therapists observed quite the opposite effect in several of their clients. Erin reported that the independence of one of her clients was inhibited by his EA, who tried to anticipate the student's every move. A similar finding was reported in Rivers and Griffith's (1995) case study of three children in inclusive settings and in a case scenario recounted by Hehir (2002). Jesse observed one of her clients "babied" by classmates, an approach which further reinforced the student's dependence and

passivity. Rivers and Griffith's report suggests that regular students in inclusive classrooms require extensive coaching and modeling by adult specialists to facilitate effective and appropriate interaction between the exceptional children and classmates. Given the severity of personnel restrictions reported by therapists throughout this study, perhaps in the classroom Jesse observed for example, this coaching and role modeling was not taking place. Students were thus required to fall back on the traditional patterns of interaction they had learned with infants, whose motor and behaviour patterns these children with disabilities most resembled. This "babying" or "independence through others" phenomenon needs to be more systematically explored in future studies.

In sum, it was the therapists' opinion from their observations of children in inclusive schools, that some children with exceptionalities were not full participants in school life. Many of the children, therapists reported, instead of being integrated with their regular cohort, seemed isolated from group activities. Therapists felt this situation appeared to worsen as the children matured and the physical and intellectual differences became more pronounced. In selected cases participants reported that children with disabilities were being encouraged to become even more dependent on others instead of developing their own autonomy and independence. It must be noted however, that these observations are based solely on the perceptions of participants in this study. To provide a more comprehensive analysis of the inclusive model additional information is required such as, for example, these children's academic scores, their social skills, and their degree of their disability. These findings offer a selected and limited view of the inclusive experience based solely on these therapists' perceptions.

Therapy Services – Uncoordinated, Fragmented, Limited

During the preliminary phase of this study, it appeared that therapy services for school-aged children were to some extent limited and not well coordinated amongst disciplines and between sectors. Reports from the therapists confirmed this hypothesis and in fact, accentuated how severely services have been reduced and fragmented. School therapists such as Angie indicated that she saw most students on her caseload once a month or every six weeks, for consultation only. Annie, also a school therapist, described how some of her clients were seen in the same setting by one SLP for language problems and another for articulation difficulties. Caroline, a health care agency therapist, revealed that many of her clients were also seen by therapists in schools; but they sought out her services periodically when mobility problems or pain arose requiring direct, intensive therapy. Both Caroline and Margot who were also agency based, claimed they had very limited, if any, contact with the therapists treating their clients in schools. In short, the therapists in this study revealed that therapy services in schools were limited and infrequent and that communication among practitioners for issues related to the same client, was virtually nonexistent. Therapists reported that parents were being forced to seek out in piecemeal fashion, the services they felt their child needed from a wide variety of sources.

A recent survey by CanChild (the Centre for Childhood Disability Research) published in a series of reports (King et al., 2000a; King et al., 2000b; M. Law et al., 2001), examined in depth the utilization of children's rehabilitation services in Ontario, that is the services accessed through children's treatment centres and as appropriate, through Community Care Access Centres. Their survey results support the findings of this study that parents access rehabilitation services from a variety of sources and settings. Survey results revealed that surprisingly only a very small proportion of children (16.8%) received services from only one therapy source, while

68.2% went to two to six different agencies and a substantial 14.4% sought interventions in over seven different sites! It must be noted however, that the respondents to the CanChild survey were accessed through publicly funded children's treatment centers and Community Care Access Centres (CCACs). Furthermore, both parents and service providers indicated that in their opinion, coordination of therapy services need to be improved (King et al., 2000a), again findings which are consistent with the present study. The authors' summary of their findings, "The fact is that families deal with multiple service providers and multiple service locations" (King et al., 2000b, p. 13), is reflective of the service profile within the public sector. This statement makes no acknowledgement of the substantial impact of the private sector in therapy service provision, a finding identified in this study.

More specifically, the CanChild (Centre for Childhood Disability Research) report underestimates the extent to which services are fragmented and uncoordinated. First and most importantly, the survey reported by King et al. (2000a,b) and M. Law et al. (2001), as mentioned previously, was carried out on a select group of parents and practitioners from children's treatment centres and CCAC agencies, all publicly funded services espousing a family-centered philosophy. Secondly, the surveys were distributed in the first half of 1999, and even since this recent date, therapy services to schools have continued to be cut. It is thus questionable if the findings are fully representative of today's restrained environment. Furthermore, the CanChild study did not take into consideration the impact of the rapidly growing private sector in rehabilitation services delivery.

Therapists in this study such as Annie, Lesley, and Erin, revealed that many parents were becoming increasingly dissatisfied with only consultative services available in the public sector; in response they were seeking out the services of private therapists to provide direct therapy. The

CanChild studies failed to tap or even acknowledge the expanding private sector of therapy service delivery which is filling the gap for parents desperate to obtain additional therapy for their child. Private therapy services are available, however, to only a privileged few, namely those with employer's insurance to pay a portion of the costs, or to parents with significant means to pay for therapy directly.

The demographic data of Ontario families with children with disabilities was felt by CanChild authors to be representative of the general Ontario population (King et al., 2000a). The report indicated that 65% of families claimed income levels between \$15,000 and \$75,000, while only 23.1% of respondents reported incomes over \$75,000 per year. There was no reference in this report to the percentage of families who carried appropriate insurance coverage for additional therapy. Recent contact with privately employed therapists revealed that therapy assessment and treatment costs could run from \$80 up to \$150 per hour (W. Jelley, personal communication, May 7, 2002). Private therapists indicated they all had significant waiting lists of clients who wished to access their services. The present study provides evidence of a rapidly emerging and growing two-tiered system in the area of children's rehabilitation services. However as Pam reported earlier, most of her clients confessed to not having third party insurance and hence could not afford private services; these children therefore have no access to additional therapy services. Only a minority of privileged families can afford private therapy services at these rates. Disadvantaged individuals are thus being further marginalized by their lack of access to appropriate services, an indication of the gradual erosion of our health care system and violation of the principles of accessibility and affordability enshrined within the Canada Health Act (Rachlis & Kushner, 1994). There is an urgent need for further research

examining factors behind the growing private sector in therapy service delivery and the impact on children and families from diverse socioeconomic backgrounds.

A recent release by the College of Physiotherapists of Ontario (2002) reflects the reality of the present status of two-tiered therapy services. The College acknowledges that individuals may wish to “supplement the publicly-funded portion of care” (p. 5) by seeking the services of private therapists. Practice of this nature is approved by this regulatory board as long as certain criteria such as common goal setting and on-going coordination are adhered to. The College insists: “It’s important that physiotherapists providing concurrent treatment with a second practitioner establish a clear method of communication between themselves and among themselves and the patient”(p. 5). According to therapists such as Emma, collaborative goal setting was “too difficult”, too much effort, and was not encouraged by her employment agency. Angie claimed that unfortunately from her perspective, mutual goal setting and on-going inter-therapist communication was largely the exception rather than the rule. Caroline did not see the need for working with others to set mutual goals, in her words, “My goal is with that patient!” In light of the present reality, this College’s guidelines appear idealistic, perhaps naïve, and very difficult to reinforce.

Therapists in this study indicated that the division of funding between two provincial ministries, Health and Education, further complicated therapy service delivery. Jesse insists that providing health-funded services in an education sponsored institution yields complexities in relation to role expectations and deliverables. Emma reported it was difficult to address the continuing education needs of educational personnel when funding is health-related to specific clients. Angie found that the lack of up-to-date client medical information in the educational environment at times hindered her ability to provide effective treatment. O'Connor (1995)

reported similar findings in a case study of a child with severe disabilities integrated into the regular school system. In his report he highlighted the incompatibility, lack of communication, and inflexibility which existed between organizations providing health services and those offering education. The child in question had great difficulty obtaining required therapy services, communication between services was ineffective, and therapeutic goals and objectives were not effectively integrated into the child's educational programming, all issues identified by therapists in this study.

SLPs in the present study revealed a very complex picture of how Ministries of Health and Education guidelines determine seemingly arbitrarily, the delivery of communication therapy services according to the nature and definition of the child's communication diagnosis. Based upon what the therapists feel are largely artificial guidelines, some children have access to two SLPs while others fall through the cracks and have no access to publicly funded services. Annie related the story of a client who uses technical aids for communication. As the child's primary diagnosis fell neither under the articulation category nor that of language skills, the child was ineligible for school-based services. Marie, on the other hand, identified clients on her caseload who were classified under both categories and therefore received the services of two SLPs, one to address each problem. These findings are similar to the status of speech-language services reported in a recent study from England. J. Law et al. (2001) discuss what they term "the 'border dispute' between health and education services" (p. 133). The researchers reported issues related to funding, recruitment, and retention of SLPs, and lack of coordinated programming severely impacted upon the quality of services provided. Their recommendations include mandated strategic planning approaches between both health and education ministries at local and national levels. The findings of the present study suggest that a similar strategy would

be highly beneficial within the Canadian context. The impact of the division of services between these two ministries deserves further examination.

The study by King et al. (2000a) indicated that over half the children surveyed were receiving OT, SLP, and PT services at least once a month, and frequently more often. This is in sharp contrast to the findings of this study in which children with physical disabilities in inclusive schools were at best receiving the services of a consultant therapist once a month. According to participants such as Cynthia, children especially those nearing adolescence, were not receiving the on-going mobilization therapy their conditions required. After a relatively short period of a month to six weeks these children had lost previously acquired abilities such as standing and walking and thus were failing to progress and even deteriorating in their physical status. Best practice clinical guidelines suggesting the most effective therapy interventions and frequencies do not exist, due perhaps to difficulties controlling for variability in treatment approaches, and complexities and variation in children's conditions (Bax, 2001; Bower, Michell, Burnett, Campbell, & McLellan, 2001).

King et al. (2000a) reported that children over the age of 13 continued to receive therapy services, the authors concluding that "children continue to receive services into and through adolescence, suggesting their problems are long-term" (p. 15). This observation is in distinct contrast to the findings of this study in which therapists revealed adolescents were either discharged from treatment completely or their consultation frequency greatly reduced. While Pam acknowledged the importance of maintaining the optimal status of adolescents with physical disabilities through rapid growth periods, it appears from therapists' reports that children were receiving minimal if any therapy and were subsequently demonstrating marked deterioration in their physical condition and independent mobility. An analysis of the long-term effects of

therapy cessation in terms of clients' quality of life and the potential economic impact demands further study.

In sum, the findings of this study support overall the therapy access trends of multiple providers and sources outlined in the literature. However existing studies fail to acknowledge the rapid growth of private rehabilitation services which have recently expanded to fill major gaps within the public sector, and therefore underestimate the degree to which existing services are splintered and fragmented. The expansion of the two tiered system in rehabilitation services is a reflection of the continuing erosion of our existing social/health infrastructure which further disadvantages those already marginalized by inequities in socioeconomic status.

The Treatment Dilemma – Consultation Model or Direct Therapy?

It was the impression of therapists in this study that economics were playing a dominant role in shaping the coordinated educational and therapy service delivery policies for children with disabilities. The move almost exclusively to the consultant model within the inclusive paradigm, which actually took place while many therapists in this study were working within their agencies, was viewed by participants as being primarily financially driven rather than being based upon the welfare of children. Emma's impressions that, "We used to be very client focused.... And now I find our decisions are based on money", are echoed by Lesley who states, "What's driving the consultative model is money, not efficacy... it's saving money!" Gow et al. (1988) in an early work on the risks of integration cautioned, "Governments must accept that integration is not a cheap alternative to segregation; it may be just as costly in view of the level of support services required" (p. 19). Nonetheless, in this province, congregated facilities for children with disabilities are being downsized and essential therapy resources severely cut (Hughes, 2002; Laucius, 2002a). A recent report predicting extensive cuts (\$11.6 million) to

special education in general warns, “more than 800 students would be pulled out of special education classes and put into regular classrooms” (Laucius, 2002b, p. B1). It appears the most practical method of distributing limited therapy services within inclusive education is through the consultant model; and while this model meets Ministry objectives, according to the perceptions of therapists in this study, this strategy is not meeting the children’s required needs.

The change in therapy service delivery model from direct treatment to a consultative paradigm is suggested to be an effective means to address the increasing need for therapy services in light of limited or restricted resources (Kemmis & Dunn, 1996; Sandler, 1997; Whitworth, 1994). Other researchers suggest that the consultative paradigm is most appropriate from a social justice and educational perspective, in that the child with disabilities remains in the classroom and the therapy interventions are meaningfully integrated into classroom activities (Giangreco, 1995; McWilliam & Bailey, 1994; McWilliam et al., 1996; Wolery & McWilliam, 1998). However there is little, if any, documented evidence to support this model of therapy intervention. While therapists in this study agreed in principle with the consultative approach, it was primarily economic pressures which they felt were most responsible for the move to the highly restricted consultation model they were mandated to follow in school-based practice. As revealed in many earlier sections of this report, it is the therapists’ impression that the pure consultative model is not providing the therapy required for children with disabilities to actualize their potential and this is serving as a great source of professional frustration. More research is needed to document the outcomes of the consultative approach to therapy delivery.

Bundy (1995) defines three types of therapy intervention in school-based practice. The first, consultation, assists teachers and parents to understand the child’s behavior, provides management strategies, and should ideally result in environmental changes to maximize the

child's potential within the school environment. The second, monitoring, occurs when the therapist supervises the individual(s) applying therapy to ascertain the application is appropriate. The third, direct therapy, is utilized when the child needs specific practice to acquire a direct skill. While Bundy views consultation as the preferred model, she acknowledges that considerable time and effort is required to develop the sound foundations upon which effective partnerships are based.

The consultative model of therapy delivery is not meant to totally replace direct treatment approaches. Rourke (1996) ascertains that even with the consultation paradigm, "it's essential that qualified, experienced therapists continue to be used to plan, implement, and supervise occupational therapy services" (p. 699). J. Law et al. (2001) assert that "the 'consultative model' should not be taken to mean that all SLP time is devoted to working indirectly through teaching assistants" (p. 135). They stress that the increased demand for professional SLP services should be acknowledged and addressed such that the children with specialized communication needs can receive the essential direct treatment they require. King et al. (2000a,b) also acknowledge the importance of the dual role of therapists which encompasses both consultation and direct treatment. They suggest that, "due to the complex nature of their [the children's] needs, it is important to continue to provide **comprehensive and individualized services** for children with disabilities. This further implies that therapists and clinicians require **specialized expertise and experience** to deliver effective services" (bolding emphasis in original document) (p. 21). Thus while the literature seems to indicate that the consultation model in itself is not sufficient to meet the needs of all children, this seems to be the model which prevails within the educational sector.

Participants in this study reported that there is barely sufficient time to interact briefly with teachers and other educational personnel. Thus the establishment of effective and

meaningful partnerships seems totally beyond the realistic possibilities of today's educational environment. For the most part therapy interventions are not being integrated into classroom activities, and if they are, the goals are so reduced that the impact is minimal or even deleterious. Therapists complained there was not even sufficient time to monitor the individuals who had been delegated with the responsibility of carrying out therapy programs. Thus according to the practice model outlined by Bundy above, in the therapists' eyes neither the consultation model nor the monitoring responsibilities were being carried out appropriately or effectively.

All therapists who participated in this study struggled with the evolution of the role to consultant. The attitudes they revealed during interviews reflected firmly entrenched convictions that the traditional mode of direct therapeutic intervention was the practice of choice and that the move to consultation was based purely on economic factors. Consultation in many ways became synonymous to therapists with the inclusion education paradigm, and their negative impressions of the consultative therapeutic role could also have coloured their opinion of the inclusive education model which was reflected in their comments described previously. Their comments related to both issues should therefore be considered with a healthy degree of skepticism.

There is some evidence to indicate that the therapists, especially those in school-based practice did not want the consultant approach to work. The resignation and cynicism they expressed concerning their roles, their reluctance to participate in activities that were not directly remunerated, and their unwillingness to embrace the challenges of consultation with innovation and enthusiasm could have impeded efforts to establish effective collaborative relationships. Many therapists had extensive experience working in the traditional direct treatment mode; they were thus reluctant to give up the practices they were comfortable with and valued. And while they paid lip service to the concept of consultation, they refused to embrace the challenges of this

approach constructively, creatively, and optimistically. Their comments reflect their resistance to the changes that came with new funding models, and it was not evident that they were prepared to adapt and initiate strategies to make it work. It must also be noted however, that their employment agencies also did not provide financial, educational, or professional support and incentives to facilitate the successful transition to a consultant model. The persistence and consistency of selected therapists such as Jesse and Emma demonstrated to some extent the potential of an effective consultant model of therapy delivery.

Therapists also resented that they had to compromise their professional expertise, and demonstrated self serving attitudes of protectionism in their attitudes towards teaching therapy skills to teachers and assistant. At the same time they felt guilty and dissatisfied that they could not intervene according to their professional judgement. They felt restrained by the consultation model and regretted they did not have the option to apply direct treatment which, in their professional opinion, would truly benefit their clients. These findings are consistent with numerous studies (Case-Smith & Cable, 1995; Crowe & Kanny, 1990; M. Law et al., 2001; McWilliam & Bailey, 1994; McWilliam & Sekerak, 1995) that reported while therapists supported in principle the consultative model, they continued to spend much of their therapeutic time in direct treatment. The researchers implied that these therapists were reactionary, preferring to adhere to established, familiar practices and resisting more contemporary and progressive approaches. While this may partially explain therapists' attitudes, the findings of this study suggest additional explanations of why therapists may be reluctant to completely relinquish direct treatment from their therapy repertoire. Many of these therapists were most likely experiencing similar dilemmas to those encountered by therapists in the studies reported above. They were thus reluctant to completely withhold direct treatment, which according to their

professional judgement would have the most noticeable beneficial impact on their clients' developing potential.

Similarly, recruitment and retention of experienced rehabilitation personnel has been noted as a continuing challenge in school-based practice (M. Law et al., 2001). In the present study, therapists observed that restricted practice policies, excessively large case loads, and the mandate to provide only consultation was causing many experienced pediatric therapists to leave their publicly funded, school-based positions. This finding is also supported in a recent study of SLPs reported by Blood, Ridenour, Thomas, Qualls and Hammer (2002). The rapid turnover and replacement by less experienced staff was felt by participants to impact upon the quality of services delivered, an impression also reported by parents. In the CanChild survey of providers of children's rehabilitation services in Ontario who worked primarily in children's treatment centres, King et al. (2000b) found that over 60% of service providers had over five years of professional experience in pediatrics, with some indicating over 30 years experience in this area. These authors asserted that well experienced and qualified personnel ensured that treatment goals and interventions were more appropriate and cost efficient and "has[d] been shown to lead to improved services" (p. 30).

A series of publications evaluating the service provided by novice versus experienced physiotherapists support the observations of therapists in this study and that of King et al. (2000b). When the treatment sessions of novice therapists were compared to experienced therapists ($m = 16$ years), the latter provided a greater variety of treatment options and changed approaches frequently in relation to the reactions obtained from clients (Embry & Adams, 1996; Embry & Hylton, 1996). Experienced therapists seemed to have more consistently positive results and more noticeably improved outcomes (Embry & Yates, 1996; Embry & Nirider, 1996;

Embry, Guthrie, White, & Dietz, 1996). These findings lend some credence to the belief of therapists in this study that the quality of service provided by experienced therapists is superior, more effective, and cost-efficient than that provided by novice therapists. Also, if experienced therapists are leaving school-based positions to work elsewhere, a trend supported by this study, school-based service is further compromised by the inexperience of providers.

The reports in the academic literature fail to examine the true impact of the consultation model within the reality of the demands of today's classrooms. They do not acknowledge, as did the therapists in this study that many children "fall through the cracks", many fail to actualize their individual potential, and some children even deteriorate due to the lack of consistent and quality therapy. The scholarly publications do not address the issue of substantial turnover of experienced professionals within the school system, nor do they acknowledge that substantial numbers of acutely frustrated parents with sufficient financial means are seeking the services of private sector rehabilitation services. These issues beg urgent further investigation.

In summary, in response to the second research question addressed by this study regarding therapists' perceptions of inclusion and therapy delivery, it was the impression of therapists in this study that the inclusion model for children with physical disabilities was falling short of achieving stated goals. This less than ideal educational environment was rendered even more problematic by the limited therapy services that were available to children. Due, they felt, primarily to financial forces, therapists working in schools were restricted to a consultation model of intervention which was ineffective, against their professional judgement, and compromising the status of their clients. In consequence, many parents were seeking private therapy which further reinforced the growing two-tiered system and further marginalized already disadvantaged children and families. As one frustrated therapist so aptly expressed, "If I'm a

consultant and she's a consultant, who is actually doing the therapy?" Unfortunately the answer appears to be no one. Creative solutions to address these issues within existing budget frameworks must be developed.

Professional Issues, Interdisciplinary Activities, Facilitators and Barriers to Collaboration

Dilemmas of Professionalism

The third research question addressed in this study concerns the professional dilemmas encountered by therapists during their daily practice. The complex and varied organizational systems in which the therapists were employed brought to the fore many tensions related to issues of a professional nature which emerged in their day to day practice. Professionals are described as having a unique and specialized body of knowledge (Ogawa, Crowson, & Goldring, 1999). This confers upon them the expectation of ultimate autonomy to practice according to their professional expertise, guided by a code of ethics and the expectations that they will serve only in the best interests of their clients (Bellner, 1996; Hoy & Miskel, 2001). While therapists are not generally included in the traditional professional occupations such as lawyers, physicians, and the clergy, within the therapy academic literature their status as professionals, meeting the above criteria, is openly acknowledged (Bellner; Cleather, 1995).

OTs, SLPs, and PTs, in their initial professional training, are educated to be autonomous front-line practitioners. They are self-regulated by provincial colleges and while their titles are protected and their scope of practice outlined in statutory laws, they have very few protected acts which prevent others from carrying out similar therapeutic activities. The frustration and disillusionment expressed by the school-based therapists can therefore be acknowledged and understood within this context. These therapists were educated within a culture of autonomous

practice which solidifies their professional identities and establishes guidelines related to power and control (Beattie, 1995). Their curricula focuses primarily on specialized evaluation and treatment applications unique to their disciplines, with little emphasis on consultation, team work, and communication in educational settings. They were led to believe they would be granted the independence and respect they were due as skilled, self-regulated professionals. Their disillusionment and frustration with having their practice controlled by agency policies, funding schemes, and individuals within the bureaucracy is therefore understandable. The therapists who chose to pursue their careers in the private sector repeatedly reaffirmed that the freedom to exercise their professional skills and expertise was the prime motivation and reward of their practice.

Ogawa et al. (1999) adds furthermore, that professionals have an orientation to “like-specializing colleagues” in that their first loyalty is to each other and their profession itself; they view each other as equals and resist supervision by organizational “superordinates” (p. 283). It is hardly surprising therefore that in the context of today’s classrooms, collaboration between educational and rehabilitation professionals is not a common occurrence. While the scarcity of time and the excessive demands of each group’s practice do not facilitate the development of trust required for effective collaboration, there are also intrinsic elements of individual professional cultures which also play a significant role. This, in turn, is compounded by the controlling nature of the educational system (Mawhinney & Smrekar, 1996; Smylie et al., 1996) and their own agencies and supervisors which create barriers to collaborative interactions.

Another element of tension identified by therapists was the conflict between personal objectives and organizational goals and expectations. Ogawa et al. (1999) describe the disparity between individual and organizational goals as the following dilemma: “How can there be a fit

between organizational goals and individual needs?” (p. 280). They state that these two elements are consistently in potential conflict and for an organization to remain viable and effective, an acceptable degree of harmony must be attained between these two opposing forces.

Clearly the objectives of the school-based therapists to provide therapy services were in continual conflict with the educational boards and rehabilitation agencies to contain expenditures. These opposing forces were not easily reconciled and thus were causing tension between frontline workers and administration. Emma was extremely frustrated when her agency, to cut costs, eliminated funding for report writing without employee consultation. Jesse also resented how her therapy interventions were under the tight control of administrative funding formulae and case managers; she expresses her resentment: “It’s very degrading, it’s very demoralizing ... I’m the professional here!”

On the other hand, the initiatives of the public health organizations to provide support for continuing education and professional development of their employees, as reported by Kate and Heather, could be viewed as an effort to marry organizational goals with personal objectives. These incentives provided by agencies helped diffuse therapists’ frustrations when the organizations were forced to address financial objectives by making significant cuts to resources and services. The goals of the professional collectivity versus the bureaucratic hierarchy, and personal/professional control versus organizational mandates, two potential areas of conflict between individuals and organizations identified by Ogawa et al. (2001), were clearly important factors in the day-to-day practice of the therapists.

Townsend (1996) discusses how institutional processes and policies shape the practice of employees. She states that in modern day organizations, power is shaped “invisibly through anonymous classification systems, statistics, policies, procedures, funding legislation, and other

organizational processes that determine what is possible in everyday life” (p. 115). The daily work practice of school-based therapists was indeed controlled by an administrative hierarchy who limited practice through funding, using an elaborate set of checks and balances to control activities. In sharp contrast, the public health organization therapists felt they had a degree of empowerment within their agency. This sharing of power, Townsend (1996) describes as “actions that encourage self-confidence, mutual respect, support, collaboration, partnerships, and interdependence” (p. 115). These latter therapists felt they had some say in the activities/priorities which took place within their organization. Although they did identify issues of tension between personal/organizational goals, for the most part these therapists felt their organization “listened” to them and thus within this context, a potential source of conflict was addressed.

Private therapists stated up front that the lack of organizational infrastructure and constraints were features they valued most in their present practice. Lesley revealed that “organizational politics” in previous public sector jobs were primary motivating factors in her move to private sector employment. Erin affirmed that the control she had over her own practice was one of the strongest attributes of her private employment, which she described as: “It’s a pretty nice world I get to work in!” Amongst therapists there was implied reference to an unstated hierarchy with private therapists who had full control of their practice at the top of the scale, and those in school-based, controlled service delivery at the other end of the spectrum.

In sum, the variety of organizational systems within which the therapists in this study were employed permitted an examination of potential tensions of a professional nature which impacted upon their practice. The school-based therapists identified pressures related to professional autonomy and incongruencies between personal and organizational goals as important sources of conflict. The health organization employed therapists on the other hand, felt

that their agencies made an effort to address personal/professional objectives and in this way they could compromise their expectations when at times organizational goals seemed to impact upon their practice. Private sector therapists purposefully withdrew from organizational infrastructures citing professional autonomy and freedom from potential conflicts as the prime motivators in their choice.

Collaboration Within and Among Therapy Disciplines

Therapists in this study demonstrated general support for the concept of collaboration. Their views are consistent with that of participants reported in the literature who supported the principle of interdisciplinary partnerships (Case-Smith & Cable, 1995; Rainville et al., 1996). Similarly therapists felt that collaborative practice, if it took place, would improve the overall orientation and quality of treatment (Case-Smith & Cable; Edwards & Hanley, 1992). Surprisingly territorialism which is reported to frequently occur in initiatives of an interdisciplinary nature (Crowson & Boyd, 1993; Smylie et al., 1996) did not seem to be taking place. In fact therapists were very adamant in asserting their view that role protection within the therapy disciplines was not an issue. Therapists wanted, perhaps, to appear to outwardly embrace collaborative practice, while at the same time they acknowledged with limited therapy resources available, territorialism was not in the best interest of their clients.

While interdisciplinary collaboration was not the norm in the day-to-day practice of therapists, the therapy disciplines, which tended to work together followed similar trends to that reported in the literature. In this study, consistent with the findings of McWilliam and Bailey (1994), the PTs were inclined to be the discipline most strongly supportive of solitary, direct, hands-on practice. Cleather (1995), in her report on the development of the physiotherapy profession, acknowledged that PTs were noted for their preference to practice in isolated, non-

collaborative models. McWilliam and Bailey (1994) suggest that PTs have a more curative focus to their practice, which reinforces their direct, skill improvement approach to treatment. Bellner (1996) asserts furthermore, that the positivistic, medical-model-based curriculum of PTs reinforces their self-perception of exclusive skills and elevated professional status, which in turn promotes autonomous professional activity.

While interdisciplinary collaboration was not generally occurring in this study, both OTs and SLPs demonstrated more receptiveness and voiced stronger motivation to coordinate their efforts. This observation is similar to the findings reported by McWilliam and Bailey (1994), in which OTs were the most supportive of inclusive, collaborative practice followed by SLPs, and finally PTs. These authors attributed this difference to the highly functional focus of OTs as reflected in their goals and treatment approaches.

The OTs in this study demonstrated a very strong orientation to the social model of disability, described by Barnes et al. (1999) as societal and environmental constraints that limit the daily functioning of individuals with disabilities. This definition supercedes more traditional models of disability, which view impairment as a personal deficit requiring correction (Barnes et al.). The OTs placed a very strong emphasis on their clients' abilities to function within their normal societal context, and treatment was focused on adaptation and accommodation as compared to the curative model demonstrated by the PTs. The SLPs, while not espousing the social model of disability per se, were highly oriented to the necessity for communication to be appropriate and effective in a variety of normal contexts. This inherent philosophy was likely largely responsible for their flexibility and openness to collaborative endeavors.

The OTs' struggle to define and communicate the scope of their practice was an issue highlighted in the literature and reconfirmed in this study. OTs mentioned repeatedly that they

felt their impact on clients and their opportunities for intervention were strongly limited by a public lack of understanding of the potential scope of their practice. This ambiguity of roles and responsibilities was also identified by OTs in the study of Niehues et al. (1991), who attributed this lack of clarity, in large part, to the therapists' professional training within a medical model which did little to prepare them for work within an educational context. Bellner (1996) states that the PT curriculum adheres closely to the medical paradigm. OTs on the other hand, "have a more humanistic, cultural, and dynamic view of knowledge" (p. 151) which is less well defined than that of the PTs, and thus it is more difficult for OTs to persuade clients and colleagues that "their knowledge and technologies are unique" (p. 160).

In sum while interdisciplinary practice was not a frequent occurrence in the day-to-day practice of therapists, OTs and SLPs demonstrated a greater openness to collaborative activities most probably due to their functional orientation to goal setting and treatment and their belief in a societal definition of disability. PTs on the other hand, exhibited greater tendencies towards independent direct practice, possibly on account of their very skill oriented corrective approach to treatment. For the most part however, in this study collaboration among and between disciplines was the exception rather than the rule.

Facilitators and Barriers to Collaboration

The therapists in this study identified many factors, which either facilitated or served as barriers to collaborative activities with each other and educational personnel. This information is synthesized on Tables 2 and 3, pages 187 and 188 in Chapter 7. The discussion in this section highlights these findings in relation to the academic literature.

Facilitators to Collaboration

Throughout their interviews the therapists identified many factors which they felt promoted the development and functioning of effective partnerships with each other and other professionals. According to therapists their ability to collaborate effectively with others was facilitated by factors relating to their work environment, communication mechanisms, and personal attributes of individuals. There is little documentation in the literature identifying facilitators to collaborative practice. King et al. (1998) reported that family-centered practice and the establishment of a team approach to functional goal setting, facilitated effective collaboration among therapists, parents, and teachers. In part, this finding is consistent with the therapists' reports that regularly scheduled team meetings supported disciplinary and interdisciplinary collaboration; however regular meetings are only one component of family-centered practice. Therapists in this study who acknowledged a family-centered approach, did not reveal whether they felt this model had any influence on their collaborative partnerships.

Barriers to Collaboration

Not surprisingly, therapists in this study identified a far greater number of barriers than facilitators to effective collaboration. The barriers to collaboration are outlined in Table 3, page 188. As with the facilitators, barriers to effective collaboration fell under the three themes of work environment, communication mechanisms, and factors related to individual practitioners. Many of the barriers highlighted by therapists in this study are consistent with those documented in the literature especially under the theme of work environment. Factors such as travel and heavy schedules (Blood et al., 2002; King et al., 2000a; McWilliam et al., 1996), lack of time and human resources (Crowe & Kanny, 1990; McWilliam et al.), and lack of support by

administrators (Crowe & Kanny, 1990; Edwards & Hanley, 1992, Rivers & Griffith, 1995) are all supported by studies in the literature.

Other factors identified in the literature such as lack of control over service planning (McWilliam et al., 1996), funding restrictions which control treatment options and delivery (Crowe & Kanny, 1990; Edwards & Hanley, 1992; McWilliam et al., 1996), and lack of available, appropriate facilities (Crowe & Kanny 1990; Edwards & Hanley, 1992) were all clearly identified by therapists in this study as barriers to their service delivery. They were not, however, specifically reported by therapists to be detriments to collaboration.

In this study therapists highlighted a number of factors impeding effective partnership development which have not previously been identified in earlier reports. These include: factors related to communication such as technological devices including email and voice mail; the inability to access the full medical record in a timely fashion; poorly structured team meetings; part-time versus full-time therapist schedules; having to work through the intermediary of the case manager; professional language or jargon; lack of motivation or willingness on the part of individuals to collaborate; and a lack of recognition or respect for the roles played by other disciplines. Participants mentioned that frequently several issues combined to interfere with their efforts of collaboration.

In sum, in response to the research question addressing the professional dilemmas faced by therapists in their every day practice, participants' responses were a direct reflection of their employment environment. School-based therapists identified pressures related to professional autonomy while health organization therapists recounted conflicts between personal and organizational goals. Private therapists cited professional autonomy as a prime motivators in selecting private sector practice. Therapists in this study highlighted a number of factors, which

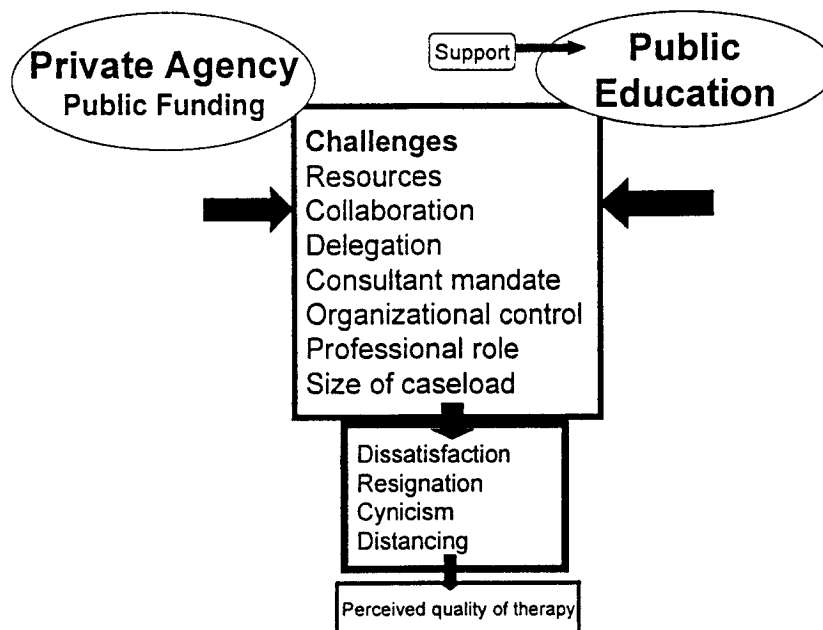
promoted collaborative practice and had not been previously reported in the literature. The identification of factors that facilitate collaborative activities may suggest strategies to encourage coordinated goal setting and management even in today's complex and pressured environment. The barriers to effective collaborative practice for children in inclusive schools identified by therapists in this study were for the most part similar to those previously outlined in the literature, indicating that many factors in play in American settings also have relevance to Canadian classrooms. This study highlighted however, the multitude of barriers that impede therapists' efforts to coordinate activities, which render collaborative practice exceedingly rare.

Synthesis

The findings from this study related to how therapists felt the inclusion model and organizational factors were impacting on their practice are synthesized in the following diagrams. This study has identified four distinct groups of therapists: public education, public health care, publicly funded private agency, and private practice. Therapists working directly in schools, that is, those employed by the publicly funded private agency and public school boards, identified similar emergent themes which are represented in Figure 1. These therapists noted a number of challenges related to their practice including a lack of resources, difficulties with collaboration, a strict consultation mandate which forced delegation of therapy to others, and organizational control which impacted on their professional autonomy. All these factors contributed to the therapists demonstrating feelings of dissatisfaction, resignation, cynicism, and distancing related to their practice. These therapists felt that the quality of therapy service they were delivering was poor and steadily deteriorating. The public education therapists did,

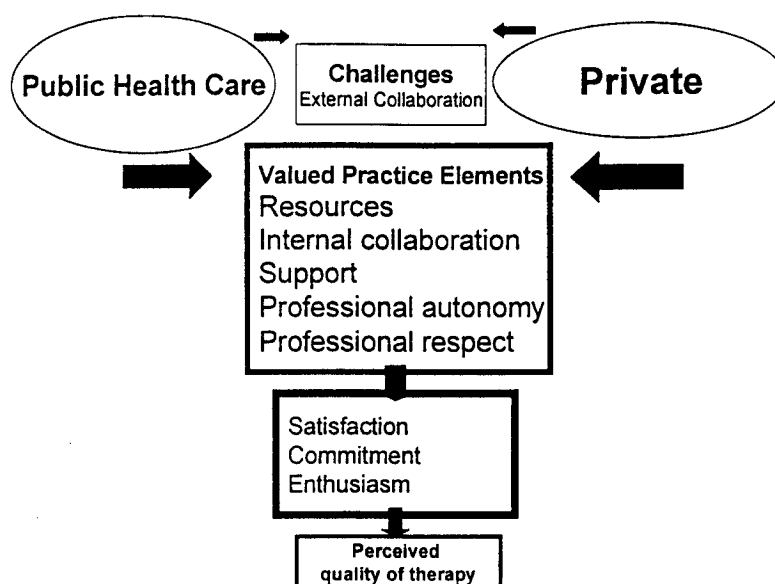
however, acknowledge the support they received from their organization for professional development and growth.

Figure 1. Themes identified by therapists practising in inclusive settings



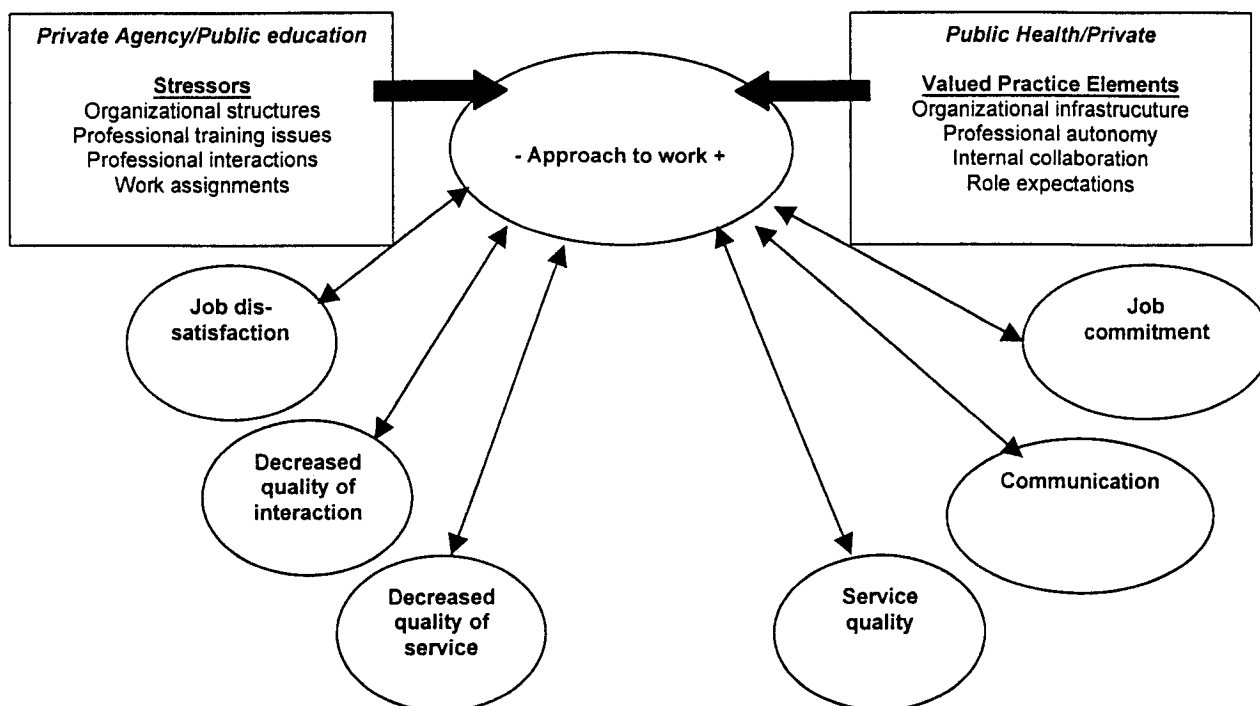
The therapists practising in public health care settings and those in private practice revealed similar themes related to their professional practice which are illustrated in Figure 2. While these therapists revealed that collaboration with others outside their agencies was sporadic and inconsistent, for the most part they identified several elements of their practice which they highly valued. They indicated they had appropriate resources and effective collaboration and support from within their agency. Most importantly they reported that they had the autonomy to exercise their professional judgement and they received the respect they felt they deserved. Subsequently they expressed feelings of satisfaction and commitment to their practice and they felt they were delivering quality therapy which was meeting the needs of their clients.

Figure 2. Themes identified by public health care and private therapists



Wisniewski and Gargiulo (1997) propose a useful model related to occupational stressors in special education settings which consolidate many of the findings from this study. They suggest that the multiple complexities of special education settings predispose workers to occupational and professional stress. While their discussion relates predominantly to teachers, the model offers insight and understanding into the findings of the present research. The original framework of Wisniewski and Gargiulo has been adapted and expanded to reflect the findings which emerged from the rehabilitation therapists in this study. The model, which is illustrated in Figure 3, reflects not only the stressors identified by private agency (school-based) and public education therapists, but also includes the valued practice elements on the positive side of the approach to work spectrum, which were highlighted by the public health care and private practice therapists.

Figure 3. Interpretation of findings expanded and adapted from Wisniewski & Gargiulo (1997)



Wisniewski and Gargiulo (1997) assert that many of the stressors within inclusive schools result from an incoherence between worker expectations and the reality of the professional experience, a sentiment frequently voiced by the private agency and public education therapists. The researchers affirm furthermore, that stressors inherent within the inclusive special education environment are derived from four main sources, namely organizational structures, issues related to professional training, professional interactions, and work assignments, all of which were identified by therapists in this study. Wisniewski and Gargiulo claim that organizational structure is a critical element contributing to professional

satisfaction. Factors reported in the literature to be stressors within the organizational framework of inclusive environments include inadequate resources, a lack of control and input into decision making, role ambiguity, and the inability to practice according to professional guidelines. Each of these elements was identified by therapists as impacting significantly upon their ability to deliver therapy services in the school environment.

The second factor, stressors related to professional training, according to Wisniewski and Gargiulo (1997), are centered around the mismatch of professional expectations and the reality of the role in the school environment, an element mentioned frequently by all therapists in this study. The researchers assert that feelings of powerlessness, lack of control, and the inability to practice according to professional judgement are all significant sources of stress, which were also identified by the private agency and public education therapists. It is of note to add that the researchers cited reports in the literature indicating that it was the most competent teachers who tended to leave the profession. Although this finding is not confirmed in this study, perhaps the most experienced and competent therapists were more likely to embrace the risks inherent in private practice.

Many of the findings related to professional interactions, cited by Wisniewski and Gargiulo (1997) as a third major source of stress, were also identified by therapists in this study. The professional isolation experienced by workers in special education settings, the lack of administrative support, and the unsatisfying nature of interactions with other personnel and parents identified by Wisniewski and Gargiulo, were all acknowledged by therapists working directly in schools. The final issue related to work assignments suggests that indifferent attitudes on the part of administrators, the complexity and overwhelming nature of the job requirements, scarcity of resources, and a lack of professional development and career opportunities, contribute

to dissatisfaction and stress within the inclusive environment. Again all these factors were acknowledged by therapists in this study as important elements in their everyday practice in schools.

Wisniewski and Gargiulo (1997) propose that the unique demands of special education and inclusive classrooms contribute to high levels of occupational stress and professional dissatisfaction, which can eventually lead to the development of burnout. They describe this condition as, “a syndrome of emotional exhaustion and cynicism that occurs in response to the stressors and strains of professional life” and is characterized by “emotional exhaustion, depersonalization,.... and reduced personal accomplishment” (p.329). They describe burnout as a developmental process along a continuum. While it is not the intention to imply that therapists in this study were in a state of burnout, their comments and reflections are in keeping with many of the reported characteristics described above. Therapists, especially those in school-based practice, demonstrated attitudes of cynicism related to their working environment, their administrators, and the potential of their role. They expressed dissatisfaction with their role and an attitude of resignation and detachment from their clients. Many also displayed a certain exhaustion or pessimism which restricted their ability to creatively and energetically attack the challenges they encountered.

Wisniewski and Gargiulo (1997) claim that the eventual outcome of continued stress on personnel leads to problems of retention, a change in the quality of interactions between workers, and deterioration in the quality of services offered to clients. While many therapists continue to stay in school-based practice due to flexibility of this employment to accommodate family responsibilities, financial commitments, and the uncertainty of compensation in private practice, this model helps to explain the movement of therapists from public to private sector and the

problems of retention within educational settings. This model may also shed light on the lack of motivation on the part of both teachers and therapists to engage in effective interactions, the “social distancing” (p.329) perceived by many of the therapists, and the feelings they expressed that they were “no longer effective in [their] professional responsibilities with students, colleagues and parents” (p.329). All therapists in this study acknowledged that the quality of therapy services in schools had diminished. They claimed the consultation model was predominantly responsible for this change, however perhaps the deterioration in service can also be explained by the lack of motivation and interest on the part of the therapists overwhelmed by the demands they faced on a daily basis.

As noted in Figure 3, at the other end of the approach to work spectrum were the public health care and private practice therapists. These participants identified a number of elements they valued in their practice such as a supportive organizational infrastructure, autonomy and respect, support and collaboration with colleagues working within their agency, and the ability to treat clients according to their professional judgement. In turn these therapists demonstrated a strong commitment to their profession, an ease of communication, and a high degree of satisfaction with the quality of services they were delivering.

In sum, the proposed model of occupational stressors and valued practice elements adapted and expanded from the original framework of Wisniewski and Gargiulo (1997) provides a useful lens with which to examine and synthesize the findings of this study. These researchers hypothesize that the special education environment predisposes workers to many stressors on account of scarce resources, professional isolation and inadequate support, unsatisfying professional interactions, and a lack of professional role fulfillment. All these elements were identified and confirmed by therapists in the present study. Wisniewski and Gargiulo suggest

furthermore, that ultimately the effects of these stressors can become cumulative, producing job dissatisfaction on the part of employees, diminished quality of service to clients, and eventually a lack of ability to retain experienced and competent workers. Therapists in this study reported all these findings. Potential strategies offered by the researchers to ameliorate the situation include mentorship, administrative assistance and support, and programming at pre-diploma and graduate levels to prepare individuals to deal with workplace stress. These suggestions are appropriate and useful strategies, which could address many of the issues identified by therapists in this research. The adapted and expanded model presented here also highlights the valued elements of practice noted by therapists working in public health care and private practice settings. These positive features promoted commitment, communication, and a high degree of satisfaction on the part of therapists with the quality of services delivered, and perhaps also served to mitigate against potential workplace stressors.

Chapter Summary

In summary, this chapter has attempted to frame the present study within the existing scholarly literature indicating where there is support for existing findings, where gaps or inconsistencies exist, and what new information this inquiry has uncovered. School-based therapists confirmed that their work activities adhere to the recommended practice of serving primarily as consultants, teaching educational personnel to apply required therapy regimes. In reality, however, therapists revealed that effective on-going partnerships with educational personnel do not exist in today's educational environment due to personnel shortages, excessive individual demands, and insufficiently trained workers. There is neither the time, motivation, nor energy required to forge collaborative partnerships. Therapists are therefore forced to assume the

bizarre role of working as consultants in isolation, prescribing limited programs which are either carried out inappropriately or not at all. The children with physical disabilities in inclusive settings are therefore receiving very little therapeutic programming, and in some cases their abilities are failing to progress or even deteriorating. The frustration of therapists in this highly restricted professional role is causing many to seek employment in the private sector.

In the participants' opinion, the inclusion model of education did not seem to be fostering the social and psychological benefits of interaction with same-aged peers reported in the academic literature. In fact, therapists observed selected children who were shunned and isolated; integration into regular activities was rendered even more problematic by the limited therapy programming available due to the ineffective application of the consultant model. To compensate, many dissatisfied parents were seeking alternate sources of therapy services, a trend supported in the literature. Existing reports fail to acknowledge however, the findings uncovered in this study of a rapidly growing private sector utilized by a minority of parents, further disadvantaging those with insufficient financial means.

The variety of organizations represented by the therapists in this study permitted an examination of several potential sources of conflict experienced in day to day activities. The loss of professional autonomy and conflicts regarding personal/professional goals vis à vis organizational objectives were continual sources of frustration to therapists in school-based practice. Examination of collaborative activity amongst therapists indicated that even though OTs, SLPs, and PTs to a lesser degree supported this model, in effect very little collaboration was indeed taking place. While this study highlighted several facilitators to collaborative practice, it also identified a wide variety of barriers, which in the therapists' opinion, were responsible for reinforcing the isolated practice they experienced in their day to day work life.

This study has uncovered important issues related to the delivery of rehabilitation services for children educated in inclusive schools. More importantly however, it has identified several issues requiring further investigation. There is an urgent need to examine the impact of the consultant therapy delivery model on children and their families over the short and long-term; immediate economies in service delivery may be paying a significant toll in terms of their quality of life. Furthermore, issues related to recruitment and retention of experienced therapists within public sector agencies needs to be urgently addressed to ensure that all children with specialized needs have access to the highly skilled professionals they deserve.

CHAPTER 9: CONCLUSION AND FINAL WORDS

The original intent of this study was to examine the perceptions of OTs, SLPs, and PTs of their daily practice, as they provide therapy service for children educated in inclusive schools. The objective was to explore the challenges faced by these therapists, and through their words weave a comprehensive understanding of the personal and professional issues that they face. The study has succeeded in exposing a myriad of issues and dilemmas faced by therapists and in the process has highlighted tensions surrounding the delivery of rehabilitation services for children with physical disabilities educated in inclusive settings.

Dreyfoos (1994) proposes a vision for the full service school that: “puts the best of school reform together with all the other services that children, youth and their families need, most of which can be located in a school building” (p.12). She adds:

The charge to community agencies is to bring into the school: health, mental health, employment services, child care, parent education, case management, recreation, cultural events, welfare... and whatever else might fit into the picture. The result is a new kind of ‘seamless’ [full-service with continuity] institution, a community school with joint governance structure that allows maximum responsiveness to the community, as well as accessibility and continuity for those most in need of services (p.12).

If the findings of the present study are indicative of the experience of therapists working in inclusive settings, this vision for schools, supported earlier by the Ontario Ministry of Education (2001), is still some distance from being realized.

Based on the therapists’ perceptions, the final chapter of this dissertation will attempt to provide insight into the factors uncovered by this study which limit or even hinder the provision

of needed therapy services to children in inclusive schools. The discussion will conclude with a synthesis of the contribution of this study to academic theory, an overview of soundness of the findings, implications and limitations of the study, and final thoughts related to my role as researcher.

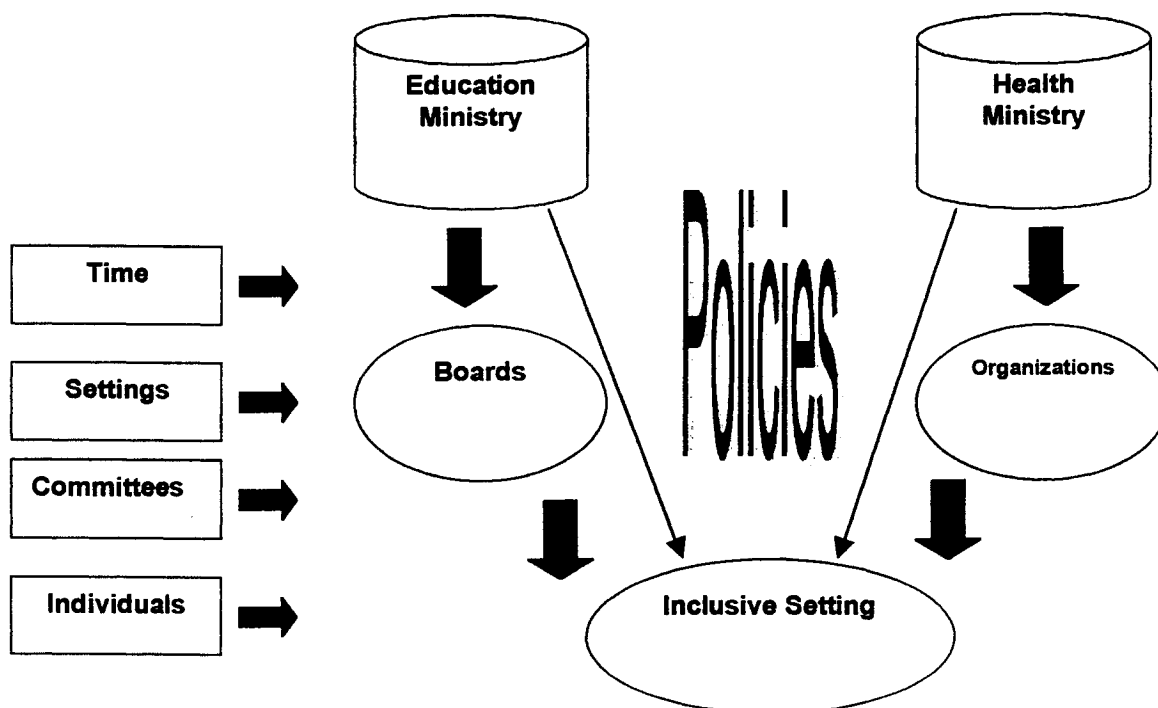
The Transformation of Policies to Practice

In principle, the concept of providing therapy services directly in schools, seamlessly linked to health and community agencies appears to make sound economic and practical sense. In reality, however, therapists reported that the services received by students are fragmented, inconsistent, and do not appear to be meeting therapeutic needs. A myriad of complex, inter-related factors provide plausible hypotheses as to why this vision has yet to be realized. A conceptual model proposed by Hall and McGinty (1997) describing policy as the “transformation of intentions” (p.462), provides a useful theoretical lens with which to analyze the findings of this study. A graphic depiction of this model has been created and is illustrated in Figure 4.

The authors describe the implementation of policy as “a dynamic transformation of intentions across phases and sites, time and space, where policy content, practices and consequences are generated” (Hall & McGinty, 1997, p.461). They emphasize that policy is emergent and changing, shaped by the various contexts, individuals, and groups through which it evolves towards implementation. The authors stress that policies are no more than the constructs of people, places, and time, subjected to the forces of power, competing access to resources, and the impact of conventions [“the taken-for-granted ways of understanding, communicating and doing” (p.462)]. In this study, policy related to the provision of therapy programming in schools was transposed and transformed through many channels including: provincial ministries; public

and private sector organizations; health and education institutions; and individual professionals and disciplines.

Figure 4. The transformation of intentions from policy to practice (Hall & McGinty, 1997)



The effective provision of rehabilitation services for children educated in inclusive schools requires the integration of health and educational policy into practice. The Ministries of Health and Education provide overarching and powerful influences on the organizations and personnel under their jurisdiction. Policy directives from Ministry sources shape global objectives while at the same time allocate specific program and service funding. For the most part, the spheres of health and education remain distinctive silos reflected in widely disparate

cultures, policies, and power structures. While there is public acknowledgement of the need to coordinate efforts between health and education for children with special needs, in reality, as seen in this study, this does not seem to filter down to the grassroots level where therapy programming is administered. This incongruence between health and education ministries, identified in the literature (J. Law et al., 2001) and suggested by therapists in this study, is reported to hinder and even prevent effective and efficient coordination of efforts. Although ministries promise at administrative levels to facilitate communication and collaborative initiatives, multiple levels of bureaucracies and highly competing priorities for increasingly scarce resources, deflect and dilute the best of original intentions.

A second factor at play in this complex portrait is the translation of policy directives into practice at education and health organization levels. In this study the controlling cultures of both education and therapy agencies shape the service delivery patterns of school-based therapists. The hierarchical distribution of power in schools, also suggested in this study, has a major influence on the creation of a climate, which either favours or discourages collaborative activity. The access to and distribution of ever increasingly scarce resources such as time, space, equipment, and personnel is under the tight control of education and health care administrators. Rehabilitation services programming within individual schools is subject to competing priorities and changing needs as determined by ministry directives, administrators, students, and teachers. Under these powerful pressures, it is easy to understand how in the greater scheme of educational priorities, rehabilitation service delivery is low in status.

Throughout this study it has become evident that health care organizations such as public health institutions, publicly funded private agencies, and private sector associations all exist in differing circumstances with conflicting priorities. Critical factors such as the continual struggle

to balance service delivery with diminishing resources, competition with other service providers, and the recruitment and retention of experienced personnel under less than ideal circumstances, all influence the interpretation of organizational policy into practice. The findings from this study suggest that public health agencies seemed to be able to balance organizational objectives with individual priorities due perhaps to supportive infrastructures and the congruence of public funding policy within traditional public health institutions. This is in sharp contrast to the conflicts which arise in publicly-funded private agencies where leadership directs practice to maintain organizational viability within a highly competitive health provider market. Policy and resultant practice went against accepted professional conventions, driven by unpopular choices which tried to balance service delivery with limited available resources. These conflicting cross pressures frequently resulted in therapist resentment and dissatisfaction. Therapists who were self-employed in the private sector translated directive policies themselves according to the guidelines and constraints of external funders. They thus had the power and autonomy to shape their own practice, resulting, they reported, in much professional and personal job satisfaction.

The third and final factor at play in this scenario is the particular struggle of school-based therapists to reconcile their new roles in light of conflicting professional expectations and organizational policy directives. While the transformation of the therapists' role from service provider to consultant may be a feasible approach to maximize available expertise, this policy change has taken place within an infrastructure that does not support this model and among people who were not educated to value or perform this function. It is apparent from this study that therapists have no commitment to their new role as consultants. Organizational administrators failed to consider and/or evaluate the impact of their policies at the grassroots level, a finding which has also been reported in the literature (White and Wehlage, 1995). The

findings of this study are similar to those recounted by White and Wehlage, where program expectations were not realized due to incongruencies between administrative idealistic objectives and the situational reality at the implementation level.

Therapists struggled to reconcile their new role as consultants within their established professional profile. Their roles were circumscribed by funding policies which restricted their strategic decision making and did not provide mechanisms to support the time and resources required for effective consultation. Surprisingly, in this era of client-focused, evidenced-based practice, there has been little emphasis on examining the impact of this professional role change or even evaluating the outcomes on the client recipients of therapy service delivery and their families.

This study has showcased an overarching theme of multiple levels of marginality. Therapists recounted how children with physical disabilities were marginalized in the classrooms and playgrounds of inclusive schools. Participants reported that some parents did not feel welcome in the school environment and therapists did not spend unpaid time contacting parents for therapy programming which took place every two to six weeks and therefore could hardly be classed as a program. The small minority of parents with financial means were finding alternate sources of therapy to compensate for the diminished programming in schools, thus further disadvantaging families and children already on the socio-economic fringes. Finally, therapists recounted an overarching theme of marginalization of themselves as professionals. They were outsiders trying to break into a foreign environment who in the end either conceded to this diminished role in order to maintain their employment or they left for the private sector in which their professional expectations could be fulfilled.

In sum, this study has shown how what appeared to be a reasonable approach to providing therapy services to children with special needs in inclusive schools has been thwarted by a myriad of factors operating at governance, organizational, and personal levels. The “transformation of intentions” (Hall & McGunty, 1997) of educational and health policy occurred incrementally and unwittingly as organizations and their leadership confronted unsolvable dilemmas and tried to balance personal and organizational objectives within a competitive context of scarce and diminishing resources. In the end, sadly, a picture evolves of a program which does not meet intended expectations, frustrates the service providers, and further marginalizes those for whom it was originally intended to serve.

Contribution of this Study to Academic Theory

This study has uncovered several issues related to therapy service delivery that contribute to the existing body of academic knowledge and theory. Despite the claims of academics and researchers that the consultant model of therapy delivery is the method of choice in inclusive classrooms, this study suggests that in the present educational environment, this approach may not be achieving desired goals. The role of therapists in schools is now restricted almost entirely to consultation. The consultant model advocates that therapists instruct teachers and assistants to deliver appropriate therapy for each student’s particular needs. However the appropriate infrastructure does not appear to be in place to permit these activities to occur. The demanding schedules of both teachers and therapists in the present educational environment inhibit collaborative interaction and activities, which are necessary prerequisites to effective consultation. Rehabilitation and educational organizations may pay lip service to the concept of collaboration, however they provide neither incentives, time, nor resources to facilitate and

support the process. It appears that for the most part, the responsibility for delivery of therapeutic programming is falling primarily to EAs, who have minimal training in therapy techniques, and whose schedules place therapy on the bottom of a large list of academic and social priorities.

It is of particular note that this paradigm shift, away from direct treatment by therapists to the full consultative model, has taken place with minimal evidence or research upon which to base this practice. If this study is any indication, in the end, the consultation process is proving largely ineffective with the result that therapy programming is so minimal its impact on students appears to be negligible. Furthermore, parental dissatisfaction with the therapy services presently available in the public school system, is causing those with sufficient financial resources to seek the services of private therapists. As a result, there is a rapidly growing private sector of therapy service delivery, creating a two-tiered system, which further disadvantages already marginalized children and families.

The worklives of Canadian OTs, PTs, and SLPs working with children with physical disabilities educated in inclusive settings has been virtually unexplored. This study reveals that many of the barriers to effective collaboration in schools, identified in American studies, are also in place in Canadian educational settings. This study highlights the professional values highly regarded by therapists, such as the autonomy to direct their own practice and utilize their expertise according to discipline standards and ethics. The research has also uncovered the struggle of therapists to reconcile their professional values with that of organizational objectives and viability. Many therapists, unwilling to compromise professional expectations, are seeking employment in the private sector leading to a problem of retention in public school settings. This research has revealed that for the most part, OTs, PTs, and SLPs, instead of demonstrating discipline specific characteristics, are more closely aligned according to employment sector, with

regard to their professional values and beliefs, and work setting seems to dictate the type of service delivery performed by therapists.

Trustworthiness of the Findings

Throughout this study, several strategies were employed to ensure the trustworthiness or authenticity of findings (Lincoln & Guba, 2000). First, and perhaps most importantly, throughout this report every effort has been made to disclose frankly and fully my reflections, alliances, and conflicts within the various phases of the study. By stating these issues up front, attempts have been made to expose the reader to elements of researcher bias which may have unwittingly influenced the interpretation of the data (Maxwell, 1996). Within the dialogue, the original data from participants has been portrayed in the rich detail they were originally obtained, so that the reader can view for him/herself whether the findings are an appropriate representation of participants' intent. Where appropriate, there have been attempts to include specific examples of the therapists' stories where the data were not in keeping with emerging themes or where there were obvious inconsistencies and incongruities. Furthermore these data were drawn from OTs, PTs, and SLPs employed in a variety of public and private sector agencies in an effort to obtain information from multiple sources and to triangulate the findings. Finally, as an additional verification, each transcript was subjected to individual member checks to ensure that the data, as represented, was deemed a reasonable reflection of each participant's meaning. Thus a series of measures have been taken to ensure that my interpretation of the data was transparent and explicit, and the findings are an accurate representation of the therapists' original intent.

Implications and Limitations of This Study

This study has a number of important implications for researchers, policy makers, educators of rehabilitation professionals, and practising therapists. The changing role of therapists from direct practitioners to consultants demands systematic research into the impact of this change on children with physical disabilities and their families. This study suggests that the lack of close follow-up and direct therapeutic intervention may have deleterious effects on the physical status and potential of school children, especially adolescents. Researchers need to investigate the outcomes of this changing model of therapy delivery on the physical, psychological, and social status of children with disabilities and their subsequent quality of life and that of their families. Changing models of practice should be urgently assessed to ensure that best practice is grounded in sound evidence. The rapidly growing private sector of rehabilitation service delivery should also be examined to provide an indication of the extent of its growth, usage patterns, and this impact on the delivery of publicly funded services.

The findings of this study have essential implications for education and health policy makers. While society policy makers attempt to assure the wise use of public funding to maximize existing resources and service, the critical conditions described by therapists in this study undermine their therapeutic efforts, potential, and morale. Rehabilitation service delivery in schools seems to be largely a function of economics and budgets. Over the years resources have been cut so drastically, the impression that therapy services are available in schools is at most a mirage. Policy makers must acknowledge first of all that there is a need for this service, that the delivery of therapy services requires professionals with appropriate expertise; delegating therapy responsibilities to already overloaded teachers or to lay personnel is not an effective solution and neither is it supported by clinical evidence. If governments do not see a need for

these services in schools, strategic planning must ensure that a minimal level of public rehabilitation service is available. Creativity and innovation is required on the part of practitioners, administrators and policy makers to ensure that a minimal level of therapy service is available to assist all young people with physical disabilities to develop their potential within inclusive school settings.

This study also has important implications for the professional education of rehabilitation therapy students. While education must focus on the fundamental assessment and treatment skills of their profession, therapist candidates must also be provided with the critical tools they need to thrive in highly competitive, demanding, and changing environments. Therapists acknowledged the difficulties they encountered working in isolation, managing a wide variety of complex activities, and reporting to a number of different stakeholders. Entry-level curricula should acknowledge the realities of the present work environment and ensure that graduates have the essential abilities they need to cope with the challenges of today's practice. Increased emphasis should be placed on the consultative and educational roles of therapists and strategies for negotiation, collaboration, and delegation outside the context of the traditional medical model.

Finally this study has important implications for therapists, their professional organizations and associations. Participants in this study revealed that they were totally unprepared for their roles as consultants working within the educational setting. Rehabilitation practitioners need to be equipped with strategies for effective team building, developing working partnerships, and successfully surviving in changing and demanding environments. Regulatory boards and professional associations must acknowledge the demands of present practice and ensure that their members are provided with continuing education opportunities to develop the tools they need to forge effective and meaningful partnerships.

Both therapists and researchers acknowledged the critical importance of experienced professionals in the delivery of effective and cost-efficient service. Therapists in this study identified organizational characteristics which made them feel valued and promoted job satisfaction; at the same time they also recognized that unfavourable working conditions were causing rapid changeover of personnel which was proving detrimental to therapy service delivery and effective collaboration. Innovative and creative strategies ensuring that employees have a voice within their agencies and are recognized for their professional contribution, will go a long way to promote retention and job satisfaction.

This study has several limitations, which must be identified. It must first be acknowledged that the findings derived from this study represent only the time and the context from which they were obtained; they cannot be considered as generalized truths appropriate to other settings or situations. The importance of these findings should not be underestimated, however. Maxwell (1996) suggests that a profound analysis of one specific case aids understanding of other comparable situations; and while the findings may not be generalizable, there is also no reason to assume that they are not applicable to other situations and contexts. Most importantly however, by examining in detail the everyday practice of therapists working within the constraints of the present education and health care systems, we are able to derive a more profound understanding of the issues they feel impact upon their daily ability to offer quality service.

These findings are representative only of the individuals and the context from which they are derived. As mentioned in an earlier section, some of the participants who agreed to take part in this study may have been more forthcoming to express their dissatisfaction with the existing system and the data may have been influenced accordingly. However this perspective may also

have been balanced by the voices of private sector therapists who expressed marked satisfaction of their roles as direct practitioners. Additional research is needed to examine how these findings compare within different Canadian constituencies and regions. The education and health care systems continue to be subjected to significant pressures and changes; further study is required to examine how the system has evolved since the time of this original research. One significant limitation of this study is that it only examined the reflections and perspectives of therapy service providers. It does not take into account the impressions and opinions of other stakeholders implicated in this study, namely children and their families; EAs, teachers, and principals; case managers, private agency, education, and health policy makers. This study, in effect, reflects only one segment of the service delivery puzzle. The critical perspectives of other stakeholders should be urgently addressed to provide a more comprehensive picture of therapy service in inclusive schools. Finally, additional research should be undertaken using multiple methodologies, including qualitative and quantitative designs, to examine not only stakeholder viewpoints, but also to measure outcomes to provide evidence for practice trends.

In sum, this study has important implications for researchers, health and education policy makers, educators of rehabilitation professionals, and the therapists themselves. This study has shed light on what therapists feel are important elements for effective collaborative practice in educational settings which promote a more seamless and efficient coordinated approach among therapy disciplines and funding sectors. Therapists have also identified significant gaps which if addressed could potentially improve the services they are able to offer. Finally this study has acknowledged several limitations with implications for future research which suggest that this project has only skimmed the surface of the issues related to the delivery of therapy services in inclusive schools. Additional studies using qualitative and quantitative methodologies, of

educational constituencies and regions, along with the impressions of other essential stakeholders will enrich and address many of the issues raised in this present work.

My Role as Researcher in this Study

My role as the researcher of this study evolved throughout the various phases of the research process. In the early stages of the development of the study, I maintained a certain distance from the project, using acquired research skills and experience to guide the conceptual phase of the process. As the interviews with participants took place and the data analysis was underway, I became increasingly involved with the reflections of the therapists and their commentary related to their challenges. Having worked as a therapist myself in school-based settings, I empathized with participants who revealed their frustration with a system over which they had no control. As a parent, I identified closely with parents who wanted more for their children than the system was prepared to give, and I empathized with published testaments of parents expressing disillusionment and frustration with the present system (Hughes, 2002; Wilcox, 2001). While followers of the positivistic paradigm attempt to remove the researcher from the study, disciples of qualitative methodology embrace the participation of the researcher in the inquiry, acknowledging the insight and meaning the researcher confers upon the findings (Lincoln & Guba, 2000). My integral participation in this study enriched not only my interpretation of the findings, but also my understanding of the events taking place around me.

Concluding Comments

To conclude, this study has attempted to provide a picture of the working lives of OTs, PTs, and SLPs in order to understand the professional challenges they encounter as they service

the needs of children with disabilities educated in inclusive settings. The “transformation of intentions” model of Hall and McGinty (1997) provides a useful lens with which to examine how visions and policies can become altered and shaped by individuals and groups involved in the program implementation process. In addition this discussion provides an overview of the trustworthiness of the findings, highlights the important implications as well as its limitations of the study, and concludes with a discussion of the symbiotic relationship between myself the researcher, and the dynamic forces that produced this study.

This study has highlighted, through the eyes of the therapists, a portrait of therapy service delivery for children educated in inclusive schools in a selected region of Canada. It has uncovered numerous tensions related to funding structures, organizational policies, interpersonal relationships, and professional values. It is hoped that examination and reflection on actual practice in light of existing policies and infrastructures will foster renewed understanding of present practices. This, in turn, may foster creative and more effective strategies for therapy service delivery, which will ultimately benefit the children served.

Appendix A

Definition of Terms

Disability: Barnes, Mercer, and Shakespeare (1999) use the World Health Organization's definition of disability which is described as, "any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (p.23).

Educational (teacher) assistant: The Ottawa-Carleton Catholic School Board (OCCDSB) defines a "special education teacher assistant as, "a support staff to a classroom where there is a child with specific needs to be met (developmentally delayed, physically handicapped, deaf, blind, or experiencing behavioural/social/medical problems)...in a global and generic sense the Teacher [Educational] Assistant provides support in the students' academic development; responds to the students' physical, emotional and hygienic needs; acts as a team member of the school in any area which may directly assist the assigned student(s), or may contribute to the educational program as a whole; and performs any duties as assigned" (p.2). In a job advertisement posted on the OCCDSB web site, the qualifications for the "ideal candidate" (p.2) include: "post secondary studies in a related field (i.e. Child & Youth Worker, Early Childhood Education, Developmental Service Worker, Braille, signing, Behaviour Technology); one year of practical experience working with special needs children; excellent interpersonal and communication skills. First aid and CPR are considered an asset" (p.2). (Ottawa-Carleton Catholic School Board, 2002, p.2).

Impairment: Barnes, Mercer, and Shakespeare (1999) use the World Health Organization's definition of impairment which is described as, "any loss or abnormality of psychological, physiological or anatomical structure or function." (p.22)

Occupational therapy: Occupational therapy within the context of the integrated classroom, is described by Wolery and McWilliam (1998) as being a discipline, which through the mechanism of activities of daily living and play is “primarily concerned with fine motor development, although many therapists also address visual perceptual skills.” (p.99) The goals of occupational therapists, described by King et al. (1998), within the same context, are related to “productivity goals (e.g. organizational skills).” (p.5)

Physiotherapy: Physiotherapy (physical therapy) is described by Wolery and McWilliam (1998) as being, “primarily concerned with gross motor development ... mobility and positioning.” (p.99) The functional goals of physiotherapists within the integrated classroom context, are described by King et al. (1998) as “mobility goals (indoor ambulation and other skills needed to move around the school setting).” (p.5)

Speech-language pathology: Speech-language pathology is described by Wolery and McWilliam (1998) as being, “primarily concerned with communication ... therapy often therefore involves labelling objects and putting sentences together.” (p.99) The functional goals of the speech-language pathologist in the integrated classroom are described by King et al. (1998) as being communication goals, (articulation/phonological skills).” (p.5)

Appendix B

Questions Guiding the Interview Sessions

1. Tell me what it is like to be a therapist working with children with physical disabilities in inclusive classrooms today. Please provide me with examples of your daily activities.
2. Describe the organization you work for and how you feel it influences your practice.
3. Describe the physical settings in which you work.
4. Describe your work day to me. (Participants will be requested to give a mini-tour of under developed aspects of the description.)
5. What service delivery model(s) do you use/prefer? Why? What factors influence your choice of therapy delivery model?
6. How do the various types of children you treat and their individual needs influence your practice?
7. What is your definition of an inclusive classroom? Describe for me the characteristics of the inclusive classrooms in which you work. Can you give me examples of how the concept of inclusion is applied in the various settings in which you work?
8. How would you describe a collaborative approach?
9. Who do you interact with to achieve your therapeutic goals? What are the challenges/opportunities for collaboration with teachers, parents, and other therapists? Can you identify any barriers and/or facilitators that influence effective collaboration? Describe particular cases, situations.
10. What are the rewards you experience in your typical workday? Please give some particular examples. Have these changed over the past years/months? What do you feel are the reasons for these changes?
11. What are the main challenges you face in achieving your therapeutic goals? What strategies do you find useful to address these challenges?
12. Where do you look for support as a professional and individual working within this environment? How does this influence your interaction with others in this setting? What personal strategies do you use to thrive (exist) in this setting?
13. How would you describe your status in the school setting?
14. In what ways did, or did not, your professional training prepare you for working in the educational environment?

Appendix C

Transcription Confidentiality Agreement

I, the undersigned, _____, agree to respect the confidentiality of the participants in the PhD study of rehabilitation therapists carried out by Dawn Burnett of the University of Ottawa.

I give assurance that no one, other than myself, will have access to the contents of the interview tapes. To this end, transcribing will be done privately and with the use of headphones. I will not discuss this project with others, nor will I discuss it with the researcher in a public place. I will not disclose any information obtained during the transcription process or during discussions with the researcher.

Following transcription, I will return all tapes, and written copies to the researcher. Copies saved on disc or hard drive will be destroyed.

In signing this agreement, I am aware that I am conforming to the guidelines for the ethical conduct of research on human subjects, as outlined by the Ethics Committee of the University of Ottawa.

Signature of transcriber

Date

Appendix D

University of Ottawa Research Ethics Board Certificate



Université d'Ottawa • University of Ottawa

Cabinet du vice-recteur
à la recherche

Office of the Vice-Rector,
Research

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for ethical approval for the research project Meeting the Needs: Rehabilitation Therapists Facing the Challenges of Integration (File 01-01-06) submitted by Dawn Burnett, and supervised by Janice Ahola-Sidaway. The members of the REB found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave the research project a Category Ia (Approval). This certification is valid for one year from the date indicated below.

Lise Frigault
Protocol officer for ethics in research,
for the Chair of the Social Sciences and Humanities REB
Tim Aubry

February 13, 2001
Date

FILE 01-01-06

550, rue Cumberland C.P. 450, Succ. A
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland St., P.O. Box 450, Str. A
Ottawa, Ontario K1N 6N5 Canada

(613) 562-5270 • Téléc./Fax (613) 562-5271



Letter of Invitation to Participants
Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé
École des sciences de la réadaptation

Faculty of Health Sciences
School of Rehabilitation Sciences

April, 2001

Dear Therapist:

I am completing a Ph.D. at the University of Ottawa, and I am writing to request your participation in my research. The purpose of my study is to understand the challenges that you, in your specific health care environment, face in delivering therapy services to children with physical disabilities who are integrated into general classrooms. For the purposes of this study, physical disabilities refer to movement disorders, which may also be accompanied by cognitive, visual, auditory and speech impairments. Increased popularity of the integration movement, coupled with decreased funding to health and education, challenge therapists to maximize resources in light of increasing needs. Your input into this research will shed light on the complexities of your work practice, therapy delivery, and the strategies you use to address the needs of the children you serve. This understanding may facilitate changes in service delivery to better meet the complex needs of children with disabilities in integrated classrooms. This information will also have direct relevance for the continuing and entry-level education of therapists in the rehabilitation disciplines.

If you agree to participate, your participation will involve approximately a 60 minute interview (subject to your time availability) and possibly, at a later date, a 60 to 90 minute focus group session. In the interview, you will be asked to describe your therapy practice in relation to children with physical disabilities who are integrated into the general education system, and to discuss the challenges you face and the strategies you use to achieve your goals. The interview will be scheduled at a time and place that is convenient for you and the discussion will be audiotaped. The focus group will address themes that arose during the interviews and any new issues, which might emerge. The focus group proceedings will be audiotaped in order to provide a complete review of discussions. You also may be contacted if need arises at a later date, to answer subsequent questions or clarify information.

Please be assured that your participation is voluntary and that there are no consequences of any sort should you wish to withdraw before or during the interview or focus group. Please also be assured that your responses and the audiotaped recordings will remain anonymous, confidential and carefully stored. Although unfortunately no funds exist to remunerate your participation in this project, your input will provide an essential contribution to revealing how health and education system restructuring and cuts, have influenced your practice and the lives of the children you serve. The results of this study will be publicised through professional conferences and journals. I would be pleased to make a copy of the final report available to you in the future, by contacting me at the number below.

Should you wish to participate in this study, please contact me at 562-5800, ext. 8022, to arrange a time at your convenience. Should you have any questions or concerns with respect to this study, please do not hesitate to contact me (number above), or my thesis advisor, Dr. Janice Ahola-Sidaway at 562-5800, ext.4079. Should you have any concerns about the ethical conduct of the research, please contact the Protocol Officer for Ethics in Research, University of Ottawa, Mme Lise Frigault at 562-5800, ext.1787. Thank you kindly for your consideration of this request. I will look forward to hearing from you.

Sincerely,

Dawn Burnett, P.T., Ph.D. Candidate



Université d'Ottawa • University of Ottawa

Faculté d'éducation

Faculty of Education

Interview Consent Form

Principal Investigator: Dawn Burnett, Ph.D. Candidate, 562-5800, ext.8022; Supervisor: Dr. Janice Ahola-Sidaway, Ph. D., 562-5800, ext. 4079, Faculty of Education, University of Ottawa.

The purpose of this research project is to develop an understanding of the work experiences, including challenges and strategies of occupational therapists, physiotherapists and speech-language pathologists, as they service children with physical disabilities in integrated classrooms. Should I agree to participate, my participation will consist essentially of attending a 60 to 90 minute audiotaped interview session to describe my practice as a therapist working with children with physical disabilities in integrated classrooms, and to discuss the challenges I face and the strategies I use to achieve my goals in this unique setting. Interviews will be scheduled at a time and place that is convenient to me. I understand that the contents of the interview will be used only for academic research purposes.

I understand that there are several potential benefits which may be derived from my participation in this study. Understanding the challenges faced by therapists during their work day may provide us with additional insight to address the daily pressures we encounter, and may facilitate alternate and perhaps innovative changes in service delivery, ultimately benefiting the children we serve. This study also has the potential to uncover issues related to professional co-ordination and communication which may have direct significance for the education of present and future rehabilitation therapists. I also understand that there is a potential risk related to my participation in this study. This activity could deal with personal information which could possibly cause me some emotional discomfort. I have received assurance from the researcher, however, that every effort will be made to minimise these occurrences.

I am free to withdraw from the research at any point in time, before or during the interview, and to refuse to answer questions without consequences of any sort. I have received assurance from the researcher that my responses and the audiotaped recordings will remain strictly confidential, carefully stored and anonymous. My anonymity will be assured by the use of pseudonyms. All data will be destroyed approximately five years after the results of this study have been published.

If there are any questions related to this study, I may contact either the researcher, Dawn Burnett at 562-5800, ext.8022, or her advisor, Dr. Janice Ahola-Sidaway at 562-5800, ext.4079. Concerns related to the ethical conduct of the project may be addressed to Mme Lise Frigault, Protocol Officer for Ethics in Research at 562-5800, ext. 1787.

There are two copies of the consent form, one which I may keep.

Participant's signature

Date

Researcher's signature

Date

Appendix G

List of Participants According to Employment Sector

Name	Employment Sector
Cynthia	Public education
Julie	Public education
Marie	Public education
Sally	Public education
Ashley	Public health care
Caroline	Public health care
Heather	Public health care
Kate	Public health care
Margot	Public health care
Pam	Public health care
Angie	Public funded private (School-based therapist)
Emma	Public funded private (School-based therapist)
Holly	Public funded private (School-based therapist)
Jesse	Public funded private (School-based therapist)
Annie	Private
Carol	Private
Catherine	Private
Erin	Private
Lesley	Private
Nicole	Private

References

- Adler, P. A. & Adler, P. (1993). Ethical issues in self-censorship. In C. M. Renzetti & R. M. Lee (Eds.), *Researching sensitive topics* (pp. 249-266). Newbury Park: Sage Publications, Inc.
- Albota, N. (2001, March 23). Improvements. *The Ottawa Citizen*, p. B1.
- Archie, V. W., & Sherrill, C. (1989). Attitudes about handicapped peers. *Perceptual and Motor Skills*, 69, 319-322.
- Barnes, C. (1999). *Exploring disability - a sociological introduction*. Cambridge: Polity Press.
- Bax, M. (2001). Does 'therapy' have a future? *Developmental Medicine & Child Neurology*, 43, 3-3.
- Beattie, A. (1995). War and peace among the health tribes. In K. Soothill, L. Mackay, & C. Webb (Eds.), *Interprofessional relations in health care* (pp. 11-26). London: Edward Arnold.
- Bellner, A.L. (1996). The impact of educational level on occupational and physical therapists' perceptions of professional status. *The Occupational Therapy Journal of Research*, 16, 147-165.
- Blood, G.W., Ridenour, J.S., Thomas, E.A., Qualls, C.D., & Hammer, C.S. (2002). Predicting job satisfaction among speech-language pathologists working in public schools. *Language, Speech, and Hearing Services in Schools*, 33, 282-290.

Bohuslawsky, M. (1999, May 15). A kidney for an education parents say. *The Ottawa Citizen*, p. C5.

Bower, E., Michell, D., Burnett, M., Campbell, M.J., & McLellan, D.L. (2001). Randomized controlled trial of physiotherapy in 56 children with cerebral palsy followed for 18 months. *Developmental Medicine & Child Neurology*, 43, 4-15.

Brown, W. H. (1997). Inclusion: A time to include and support young children. *Dimensions of Early Childhood, Summer*, 3-5.

Bundy, A. C. (1995). Assessment and intervention in school-based practice: Answering questions and minimizing discrepancies. *Physical and Occupational Therapy in Pediatrics*, 15, 69-88.

Burnett, D., Luker, K., & Mendelsohn, S. (2000). AAC Camp'99 - A multi-partnership model of success [Abstract]. *Physiotherapy Canada*, 52, S62.

Buysse, V. & Bailey, D. B. (1993). Behavioural and developmental outcomes in young children with disabilities in integrated and segregated settings: A review of comparative studies. *Journal of Special Education*, 26, 434-461.

Campbell, P. H. (1987). The integrated programming team: An approach for coordinating professionals of various disciplines in programs for students with severe and multiple handicaps. *Journal of the Association for the Severely Handicapped*, 12, 107-116.

Case-Smith, J. & Cable, J. (1995). Perceptions of occupational therapists regarding service delivery models in school based practice. *Occupational Therapy Journal of Research*, 16, 23-44.

Center, Y., Ward, J. & Ferguson, C. (1991). Towards an index to evaluate the integration of children with disabilities into regular classes. *Educational Psychology*, 11, 77-95.

Charmaz, C. (2000). Grounded theory objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 509-536). Thousand Oaks: Sage Publications Inc.

Chesley, G. M. & Calaluce, P. D. (1997). The deception of inclusion. *Mental Retardation*, 35, 488-490.

Cibulka, J. G. (1996). Conclusion: Toward an interpretation of school, family, and community connections: Policy changes. In J. C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 338-345). Albany: State University of New York Press.

Cleather, J. (1995). *Head, heart and hands: The story of physiotherapy in Canada*. Toronto: Canadian Physiotherapy Association.

Corbett, H.D., Wilson, B., & Webb, J. (1996). Visible differences and unseen commonalities: Viewing students as the connections between schools and communities. In J. C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 28-53). Albany: State University of New York Press.

College of Physiotherapists of Ontario (2002). Practice trends: Managed care models and the challenges to our members. *Communique, Spring*, 4-5.

Creswell, J. W. (1998). *Qualitative inquiry and research design*. Thousand Oaks: Sage Publications.

Crowe, T. K. & Kanny, E. M. (1990). Occupational therapy practice in school systems: A survey of northwest therapists. *Physical and Occupational Therapy in Pediatrics*, 10, 69-83.

Crowson, R. L. & Boyd, W. L. (1993). Coordinating services for children: Designing arks for storms and seas unknown. *American Journal of Education*, 101, 140-179.

Crowson, R. L. & Boyd, W. L. (1996). Structures and strategies: Toward an understanding of alternative models for coordinated children's services. In J.C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 137-169). Albany: State University of New York Press.

Danks, S. (1990). Integration of children with physical disabilities into 'ordinary' schools. *Physiotherapy*, 76, 251-254.

Denzin, N. K. & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-28). Thousand Oaks: Sage Publications, Inc.

Dryfoos, J. G. (1994). *Full-Service Schools*. San Francisco: Jossey-Bass Publishers.

Edwards, R. (1993). Placing the researcher and the research. In C. M. Renzetti & R. M. Lee (Eds.), *Researching sensitive topics* (pp. 181-196). Newbury Park: Sage Publications, Inc.

Edwards, S. & Hanley, J. (1992). Survey of interdisciplinary activity between occupational therapists and speech language pathologists in public schools. *Occupational Therapy Journal of Research*, 12, 35-49.

Embry, D. G., & Adams, L. S. (1996). Clinical applications of procedural changes by experienced and novice pediatric physical therapists. *Pediatric Physical Therapy*, 8, 122-132.

Embry, D. G., & Hylton, N. (1996). Clinical application of movement scripts by experienced and novice pediatric physical therapists. *Pediatric Physical Therapy*, 8, 3-14.

Embry, D. G., & Nirider, B. (1996). Clinical applications of psychosocial sensitivity by experienced and novice pediatric physical therapists. *Pediatric Physical Therapy*, 8, 70-79.

Embry, D. G., Guthrie, M. R., White, O. R., Dietz, J. (1996). Clinical decision making by experienced and inexperienced pediatric physical therapists for children with diplegic cerebral palsy. *Physical Therapy*, 76, 20-33.

Embry, D. G., & Yates, L. (1996). Clinical applications of self-monitoring by experienced and novice pediatric physical therapists. *Pediatric Physical Therapy*, 8, 156-164.

Ferguson, J. (1997). What students say about mainstreaming. *American School Board Journal*, 184, 18-21.

Fisher, J.B., Schumaker, J.B., & Deshler, D.D. (1995). Searching for validated inclusive practices: A review of the literature. *Focus on Exceptional Children*, 28, 1 – 20.

Firestone, W.A., & Seashore Louis, K. (1999). Schools as cultures. In J. Murphy & K. Seashore Louis (Eds.), *Handbook of research on education administration* (pp. 297-322). San Francisco: Jossey-Bass.

Forlin, C., Douglas, G., & Hattie, J. (1996). Inclusive practices: How accepting are teachers? *International Journal of Disability, Development and Education*, 43, 119-133.

Fuchs, D. & Fuchs, L. S. (1994). Inclusive schools movement and the radicalization of special education reform. *Exceptional Children*, 60, 294-309.

Fuchs, D. & Fuchs, L. S. (1998). Inclusion versus full inclusion. *Childhood Education*, 74, 309-316.

Gardner, S. L. (1993). Key issues in developing school-linked, integrated services. *Education and Urban Society*, 25, 141-152.

Giangreco, M. F. (1986). Delivery of therapeutic services in special education programs for learners with severe handicaps. *Physical and Occupational Therapy in Pediatrics*, 15, 5-15.

Giangreco, M. F. (1995). Related services decision making: A foundational component of effective education for children with disabilities. *Physical and Occupational Therapy in Pediatrics*, 15, 47-67.

Giangreco, M. F. (1997). Key lessons learned about inclusive education: Summary of the 1996 Schonell Memorial Lecture. *International Journal of Disability, Development and Education*, 44, 193-206.

Giangreco, M. F., Edelman, S., & Denis, R. (1991). Common professional practices that interfere with the integrated delivery of related services. *Remedial and Special Education, 12*, 16-24.

Gow, L., Ward, J., Balla, J., & Snow, D. (1988). Directions for integration in Australia: Overview of a report to the Commonwealth schools commission. Part II. *The Exceptional Child, 35*, 5-22.

Guba, E. G. & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Thousand Oaks: Sage Publications, Inc.

Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks: Sage Publications, Inc.

Guralnick, M. J. (1994). Mothers' perceptions of the benefits and drawbacks of early childhood mainstreaming. *Journal of Early Intervention, 18*, 168-183.

Guralnick, M. J., Connor, R. T., & Hammond, M. (1995). Parent perspectives of peer relationships and friendships in integrated and specialized programs. *American Journal of Mental Retardation, 99*, 457-476.

Hall, P. M., & McGinty, P. J. W. (1997). Policy as the transformation of intentions: Producing program from statute. *The Sociological Quarterly, 38*, 439-467.

Hehir, T. (2002). Eliminating Ableism in Education. *Harvard Educational Review, 72*, 1 – 32.

Heiman, T. & Margalit, M. (1998). Loneliness, depression, and social skills among students with mild mental retardation in different educational settings. *Journal of Special Education, 32*, 154-163.

Helmstetter, E., Curry, C.A., Brennan, M., & Sampson-Saul, M. (1998). Comparison of general and special education classrooms of students with severe disabilities. *Education and training in Mental Retardation and developmental Disabilities, 33*, 216-227.

Heron, J. & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry, 3*, 274-294.

Herrington, C. (1996). Schools as intergovernmental partners: Administrator perceptions of expanded programming for children. In J.C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 197-122). Albany: State University of New York Press.

Hoy, W.K., & Miskel, C. G. (2001). *Educational administration*. New York: McGraw-Hill.

Hughes, G. (2002, January 23). School can't find time to teach Ben to throw a ball. *The Ottawa Citizen*, p. B2.

Hughes, G. (2002, February 7). Special needs children will be left behind, officials warn. *The Ottawa Citizen*, p. B3.

Hundert, J., Mahoney, B., Mundy, F., & Vernon, M.L. (1998). A descriptive analysis of developmental and social gains of children with severe disabilities in segregated and inclusive preschools in southern Ontario. *Early Childhood Research Quarterly, 13*, 49-65.

Hunt, P. & Goetz, L. (1997). Research on inclusive education programs, practices, and outcomes for children with severe disabilities. *Journal of Special Education, 31*, 3-29.

Jenkinson, J. C. (1998). Parent choice in the education of children with disabilities. *International Journal of Disability, Development and Education, 45*, 198-202.

Kahne, J. & Kelley, C. (1993). Assessing the coordination of children's services. Dilemmas facing program administrators, evaluators, and policy analysts. *Education and Urban Society, 25*, 187-200.

Kaufman, J. M. (1993). How we might achieve the radical reform of special education. *Exceptional Children, 60*, 6-16.

Kellegrew, D.H. & Allen, D. (1996). Occupational therapy in full-inclusion classrooms: A case study from the Moorpark model. *American Journal of Occupational Therapy, 50*, 718-724.

Kemmis, B. L. & Dunn, W. (1996). Collaborative consultation: The efficacy of remedial and compensatory interventions in school contexts. *American Journal of Occupational Therapy, 50*, 709-717.

Kendrick, K. (1995). Nurses and doctors: A problem of partnership. In K. Soothill, L. Mackay, & C. Webb (Eds.), *Interprofessional relations in health care* (pp. 239-252). London: Edward Arnold.

King, G., Tucker, M. A., Alambets, P., Gritzan, J., McDougall, J., Ogilvie, A., et al. (1998). The evaluation of functional, school-based therapy services for children with special needs: A feasibility study. *Physical and Occupational Therapy in Pediatrics*, 18, 1-20.

King, S., Law, M., King, G., Kertoy, M., Hurley, P., & Rosenbaum, P. (2000a). *Children with disabilities in Ontario: A profile of children's services. Part 1: Children families and services (Rep. No. 1)*. Hamilton: CanChild Centre for Childhood Disability Research.

King, S., Kertoy, M., King, G., Rosenbaum, P., Hurley, P., & Law, M. (2000b). *Children with disabilities in Ontario: A profile of children's services. Part 2: Perceptions about family-centered service delivery for children with disabilities (Rep. No. 2)*. Hamilton: CanChild Centre for Childhood Disability Research.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy within the postmodern*. New York: Routledge.

Laucius, J. (2002a, February 6). Special-ed takes hit in \$33.7M cuts. *The Ottawa Citizen*, p. B1, B2.

Laucius, J. (2002b, August 7). Schools face massive cuts. *The Ottawa Citizen*, p. B1, B4.

Law, J., Lindsay, G., Peacey, N., Gascoigne, M., Soloff, N., Radford, J. et al. (2001). Facilitating communication between education and health services: the provision for children with speech and language needs. *British Journal of Special Education*, 28, 133-137.

Law, M. & Dunn, W. (1993). Perspectives on understanding and changing the environments of children with disabilities. *Physical and Occupational Therapy in Pediatrics*, 13, 1-17.

Law, M., Hanna, S., King, G., Hurley, P., King, K., Kertoy, M. et al. (2001). *Children with disabilities in Ontario: A profile of children's services. Part 3: Factors affecting family-centered service delivery for children with disabilities (Rep. No. 3)*. Hamilton: CanChild Centre for Childhood Disability Research.

Lawlor, M. C. & Henderson, A. (1989). A descriptive study of the clinical practice patterns of occupational therapists working with infants and young children. *American Journal of Occupational Therapy*, 43, 755-764.

Lee, R. M. & Renzetti, C. M. (1993). The problems of researching sensitive topics. In C. M. Renzetti & R. M. Lee (Eds.), *Researching sensitive topics* (pp. 3-13). Newbury Park: Sage Publications, Inc.

Levin, B. & Young, J. (1994). *Understanding Canadian schools*. Toronto: Harcourt Brace Canada.

Lincoln, Y. S. & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging influences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. (pp. 163-188). Thousand Oaks: Sage Publications, Inc.

Llewellyn, A. (1995). The abuse of children with disabilities in mainstreamed schools. *Developmental Medicine and Child Neurology*, 37, 740-743.

Lombard, R. C., Miller, R. J., & Hazelkorn, M. N. (1998). School-to-work and technical preparation: Teacher attitudes and practices regarding the inclusion of students with disabilities. *Career Development for Exceptional Individuals*, 21, 161-172.

Lortie, D. C. (1975). *Schoolteacher: A sociological study*. Chicago: University of Chicago Press.

Lupart, J. L. (2000). Inching toward inclusion: The excellence/equity dilemma in our schools. *Pan-Canadian Research Agenda*, June, 215-231.

Mackay, L., Soothill, K., & Webb, C. (1995). Troubled times: The context for interprofessional collaboration? In K. Soothill, L. Mackay, C. Webb (Eds.), *Interprofessional relations in health care* (pp. 5-10). London: Edward Arnold.

Marshall, C. & Rossman, G. B. (1999). *Designing qualitative research*. Thousand Oaks: Sage Publications.

Mawhinney, H. (1996). Institutional effects of strategic efforts at community enrichment. In J. C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 223-243). Albany: State University of New York Press.

Mawhinney, H. & Smrekar, C. (1996). Institutional constraints to advocacy in collaborative services. *Educational Policy*, 10, 480-501.

Maxwell, J. A. (1996). *Qualitative research design and interactive approach*. Thousand Oaks: Sage Publications.

McEwen, I. R. & Shelden, M. L. (1995). Pediatric therapy in the 1990's: The demise of the educational versus medical dichotomy. *Physical and Occupational Therapy in Pediatrics*, 15, 33-45.

McWilliam, R. A. & Bailey, D. B. (1994). Predictors of service delivery models in center-based early intervention. *Exceptional Children*, 61, 56-71.

McWilliam, R. A. & Sekerak, D. (1995). Integrated practices in center-based early intervention: Perceptions of physical therapists. *Pediatric Physical Therapy*, 7, 51-58.

McWilliam, R. A., Young, H. J., & Harville, K. (1996). Therapy services in early intervention: Current status, barriers and recommendations. *Topics in Early Childhood Special Education*, 16, 348-374.

Mizell, M. H., Bachofer, K., Kahl, K., Ledford, B., Miller, L., Neufeld, B., et al. (1999, April). *Using formative, qualitative program evaluation to inform systemic change: possibilities and challenges*. Paper presented at the meeting of the American Educational Research Association, Montreal, QC.

Nesbit, W. (1994). Inclusive education: views of a grammarian, not a poet. *Journal of Special Education*, 9, 119-129.

Niehues, A. N., Bundy, A. C., Mattingly, C. F., & Lawlor, M. C. (1991). Making a difference: Occupational therapy in public schools. *The Occupational Therapy of Research, 11*, 195-211.

O'Connor, B. (1995). Challenges of interagency collaboration: Serving a young child with severe disabilities. *Physical and Occupational Therapy in Pediatrics, 15*, 89-109.

Ogawa, R.T., Crowson, R. L., & Goldring, E. B. (1999). Enduring dilemmas of school organization. In J. Murphy & K. Seashore Louis (Eds.), *Handbook of research on education administration* (pp. 277-291). San Francisco: Jossey-Bass.

Olney, S. J. & Wright, M. J. (2000). Cerebral palsy. In S. K. Campbell, D.W. Vander Linden, & R. J. Palisano (Eds.), *Physical Therapy for Children* (pp. 533-570). Philadelphia: W.B. Saunders Co.

Ontario Ministry of Education. *Special education*. Retrieved April 5, 2001, from <http://www.edu.gov.on.ca/eng/document/nr/00.01/imfct1.html>.

Ottawa-Carleton Catholic School Board. *Administrative & Support Job Opportunities*. Retrieved December 20, 2002, from <http://www.occdsb.on.ca/~per/AS.html>.

Pearman, E. L., Huang, A. M., & Mellblom, C. I. (1997). The inclusion of all students: Concerns and incentives of educators. *Education and Training in Mental Retardation and Developmental Disabilities, 32*, 11-20.

Rachlis, M. & Kushner, C. (1994). *Strong medicine: How to save Canada's health care system*. Toronto: Harper Collins Publishers Ltd.

Rainforth, B. & York-Barr, J. (1997). *Collaborative teams for students with severe disabilities*. Baltimore : Paul H. Brookes Publishing Co.

Rainville, E. B., Cermak, S. A., & Murray, E. A. (1996). Supervision and consultation services for pediatric occupational therapists. *American Journal of Occupational Therapy*, 50, 725-731.

Ratcliffe, K. T. (1998). *Clinical Pediatric Physical Therapy*. St. Louis: Mosby.

Rioux, M. H. & Bach, M. (1994). *Disability is not measles: New paradigms in disability*. North York: Roeher Institute.

Rivers, E. & Griffith, A. I. (1995). Organizational knowledge and interpersonal experience. *Journal for a Just and Caring Education*, 1, 275-295.

Roberts, C. M. & Lindsall, J. S. (1997). Children's attitudes and behavioural intentions towards peers with disabilities. *International Journal of Disability*, 44, 133-145.

Rourke, J. D. (1996). Roles for school-based occupational therapists: Past, present, future. *American Journal of Occupational Therapy*, 50, 698-700.

Rosenbaum, P., King, S., Law, M., King, G. & Evans, J. (1998). Family-centered service: A conceptual framework and research review. *Physical and Occupational Therapy in Pediatrics*, 18, 1-20.

Sandler, A. G. (1997). Physical and occupational therapy services: Use of a consultative therapy model in the schools. *Preventing School Failure*, 41, 164-167.

- Sawyer, R. J., McLaughlin, M. J., & Winglee, M. (1994). Is integration of students with disabilities happening? *Remedial and Special Education*, 31, 204-215.
- Schreiber, J.M., Effgen, S.K., & Palisano, R.J. (1995). Effectiveness of parental collaboration on compliance with a home program. *Pediatric Physical Therapy*, 7, 59-64.
- Scruggs, T. E. & Mastropieri, M. A. (1996). Teacher perceptions of mainstreaming/inclusion (1958-1995). *Remedial and Special Education*, 13, 59-74.
- Sexton, D., Kelley, M., & Aldridge, J. (1998). Continuing tensions in education. *Childhood Education*, 74, 258-261.
- Smith, T. E. C. & Dowdy, C. A. (1998). Educating young children with disabilities using responsible inclusion. *Childhood Education*, 74, 317-320.
- Smrekar, C. (1993). Rethinking family-school interactions. A prologue to linking schools and social services. *Education and Urban Society*, 25, 175-186.
- Smrekar, C. & Mawhinney, H. B. (1999). Integrated services: Challenges in linking schools, families and communities. In J. Murphy & K. Seashore Louis (Eds.), *Handbook of research on education administration* (pp. 443-452). San Francisco: Jossey-Bass.
- Smylie, M. A., Crowson, R. L., Chou, V., & Levin, R. A. (1996). The principal and community-school connections in Chicago's radical reform. In J. C. Cibulka & W. J. Kritek (Eds.), *Coordination among schools, families, and communities prospects for educational reform* (pp. 171-195). Albany: State University of New York Press.

Soodak, L. C., Podell, D. M., & Lehman, L. R. (1998). Teacher, student, and school attributes as predictors of teachers' responses to inclusion. *Journal of Special Education, 31*, 480-497.

Spradley, J. P. (1980). *Participant observation*. New York: Holt, Rinehart & Winston.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Newbury Park: Sage Publications.

Townsend, E. (1996a). Enabling empowerment: Using simulations versus real occupations. *Canadian Journal of Occupational Therapy, 62*, 114-128.

Vaughn, S. & Klinger, J. K. (1998). Students' perceptions of inclusion and resource room settings. *Journal of Special Education, 32*, 79-88.

Viscardis, L. (1998). The family centered approach to providing services: A parent perspective. *Physical and Occupational Therapy in Pediatrics, 18*, 41-53.

Westby, C. E., Watson, S., & Murphy, M. (1994). The vision of full inclusion: Don't exclude kids by including them. *Journal of Childhood Communication Disorders, 16*, 13-22.

White, J.A., & Wehlage, G. (1995). Community collaboration: If it is such a good idea, why is it so hard to do? *Educational evaluation and policy analysis, 17*, 23-38.

Whitworth, J. E. (1994). The shortage of occupational therapy and physical therapy personnel in schools: Implications and actions. *American Journal of Occupational Therapy*, 48, 367-370.

Wilcox, M. A. (2001, March 27). All students will be hurt by cuts to special ed. *The Ottawa Citizen*, p. C5.

Wisniewski, L. & Gargiulo, R.M. (1997). Occupational stress and burnout among special educators: A review of the literature. *The Journal of Special Education*, 31, 325-346.

Wolery, M. & McWilliam, R. A. (1998). Classroom-based practices for preschoolers with disabilities. *Intervention in School and Clinic*, 34, 95-102.

Wolfensberger, W. (1972). *The principle of normalization in human services*. Toronto: National Institute on Mental Retardation.

York, J., Vandercook, T., MacDonald, C., Heise-Neff, C., & Caughey, E. (1992). Feedback about integrating middle-school students with severe disabilities in general education classes. *Exceptional Children*, 58, 244-258.