Learning from USA speech and language therapy service delivery models

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About the researcher

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**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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<tr>
<td>DNA</td>
<td>Did Not Attend</td>
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<td>ECSE</td>
<td>Early Childhood Special Educator</td>
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<tr>
<td>EI</td>
<td>Early Intervention</td>
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<tr>
<td>EYP</td>
<td>Early Years Practitioner</td>
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<tr>
<td>FAB</td>
<td>Flexible, activity-based, bursts of support</td>
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<tr>
<td>FIPP</td>
<td>Family, Infant and Preschool Program</td>
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<tr>
<td>IDEA</td>
<td>Individuals with Disabilities Education Act</td>
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<tr>
<td>IFSP</td>
<td>Individualised Family Service Plan</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>OT</td>
<td>Occupational Therapist</td>
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<td>PCI</td>
<td>Parent Child Interaction</td>
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<td>RCT</td>
<td>Randomised Control Trial</td>
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<td>Secondary Service Provider</td>
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<td>WCMT</td>
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Glossary

Activity setting  The specific activity that occurs during the child’s daily routine, such as mealtime, story time, playtime.

Assessment  The ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility.

Coaching  A communication style used by team members to increase caregiver and peer's capacity to support the child’s needs.

Child-centred model  Intervention tailored to the child’s interests and difficulties.

Evaluation  The procedures used by qualified personnel to determine a child's initial and continuing eligibility.

FAB scheduling  Scheduling which is based on the needs of the family and the priorities identified in the child’s goals.

Family-centred model  Intervention which considers the child within the context of his/her family.

Fidelity  The extent to which practitioners are implementing an evidence-based program or practice as intended (as defined by the Early Childhood Technical Assistance Center (Smith et al., 2015).

Health Insurance  Insurance typically taken out by Americans to cover the cost of medical care.

IDEA Part C  Government legislation in the USA on how each state provides services children from birth to 3 years old.

Individualised Family Service Plan (IFSP)  Family members and service providers jointly create a management plan to support the child based on the families concerns, priorities and resources.

Intentional modelling/Seven step process to modelling  Seven steps clinicians use to help caregivers to identify, understand and use the strategies the clinician is demonstrating.

Natural learning practices  Experiences and opportunities for the child to learn through his/her everyday life, which are available through, child and family routines, rituals, community celebrations and traditions.

Natural setting  The location a child typically spends most of his/her day, such as home and nursery.

Primary Coaching Opportunities  Opportunities for a team member to ask for advice and support from his/her peers during team meetings to help the team members better support a family.

Primary Service Provider (PSP)  A team member selected by the team to support a family and be a primary liaison between the team and the family long term.

Secondary Service Provider (SSP)  A team member selected to provide specialist advice and support to the PSP during a joint visit.

Teaming  How teams are coordinated to provide the service for patients.
1 Executive Summary

1.1 Background

Currently in the UK, Speech and Language Therapy (SLT) teams are reviewing their service delivery models to meet National Health Service (NHS) efficiency saving targets whilst continuing to meet the client’s communication difficulties. The Winston Churchill Memorial Trust (WCMT) funding provided the researcher with an exciting opportunity to investigate a family-centred approach to service delivery used in government funded centres in the USA and to consider applications for our current NHS service. Six government funded centres across three States took part during the one month visit; Texas who have recently transitioned to the model in the 12 months prior to the researchers visit, North Carolina who have carried out the three component model for 15 years and Kansas who rolled the model out state-wide. For further information about each centre visited see 8.1 Programs Visited in the USA
1.2 Key Points

1.2.1 UK Speech and Language Therapists typically use a child-centred model of service delivery and recognise the importance of caregivers as communication partners (Peacock, Konrad, Watson, Nickel & Muhajarine, 2013; Klatt & Roulstone, 2011).

1.2.2 Multiple appointments in the UK impact family life which can lead to higher non-attendance rates leading to economical costs to the NHS (Touch & Berg, 2016; Cameron et al., 2014; Bech, 2005).

1.2.3 In the USA, government guidelines suggest that clinicians must consider the child in the context of family and deliver services in the child’s natural setting (IDEA, 2004).

1.2.4 Early Intervention programs in 28 States in America use a three component service delivery model collectively known as ‘evidence-based practices in early childhood intervention’. The model comprises of 1) natural learning environment practices 2) coaching and 3) primary service provider approach to teaming (ECTA Center, 2014; Shelden & Rush, 2013; Rush & Shelden, 2011)

1.2.5 The model has been found to decrease rates of non-attendance by increasing parent participation and better meeting the child and family’s needs (King et al., 2009; Hanson & Bruder, 2001).

1.2.6 The model increases parent confidence and equips them to better support their child’s health needs within their daily routines (Edwards, Brebner, McCormack, MacDougall, 2016; Carroll, 2010).
1.3 **Recommendations**

The following recommendations have been made by the researcher for the Multidisciplinary Team NHS service providers. The recommendations have been made based on the researcher’s own experiences and data collected from direct observations, case studies, caregiver surveys and discussions gathered both in the UK and USA.

1.3.1 Caregivers as equal partners with healthcare professionals in discussions and decisions about their child’s health and care.

1.3.2 Functional intervention outcomes that are meaningful for families and promote the child’s participation in daily routines.

1.3.3 Reduce costs to NHS services resulting from non-attendance by increasing caregiver participation in interventions.

1.3.4 Structure teams to comprise of multiple disciplines of health professionals rather than profession specific teams.

1.3.5 Increase efficiency of team meetings.

1.3.6 Eradicate costs of renting and maintaining clinic rooms and equipment by implementing therapy in the child’s natural setting.

1.3.7 Reduce waiting times by prioritising children by level of need and using flexible scheduling to meet the needs of all children and families.

**Keywords:**

Service Delivery Models, Early Intervention, Child/Family-centred approaches
2 Introduction

2.1.1 United States of America (USA)

In the United States of America, a set of regulations called the Individuals with Disabilities Education Act (IDEA), Part C provides guidance on the provision of services for children with disabilities aged 0-3 years old. Under the Part C IDEA (2004) health professionals working with 0-3 year olds are required to develop therapy management plans that consider the child within the context of the family and deliver therapy services within the child’s ‘natural setting’. The term ‘family’ typically refers to a group of people that are co-dependent, but can comprise of multiple forms and structures (Office of National Statistics, 2016; Hanson & Lynch, 2013). The current report will refer to adults who care for the child as the ‘caregiver’ to encompass parents, family members and Early Years Practitioners. Services which support the health needs of children aged 0-3 years old in America are referred to as ‘Early Intervention’ (EI) programs. Early Intervention programs in 28 States in America use a family-centred approach comprised of a three component service delivery model collectively known as ‘evidence-based practices in early childhood intervention’. The family-centred approach to delivering services has been found to decrease number of hospitalisations, decrease costs and enhance family coping outcomes for children with special needs and their families that result in positive healthcare outcomes for the children (Kuo, Bird & Tilford, 2011; Kuo, Frick & Minkovitz, 2011; Crais, Poston Roy & Free, 2006; Horst, Wener & Werner 2000). The three components of the family-centred approach are 1) natural learning environment practices, 2) coaching and 3) primary service provider approach to teaming (Shelden & Rush, 2013). The family-centred approach meets the requirements of the IDEA, Part C and will be discussed in more detail below.
2.1.2 Natural Learning Environment Practices

Natural learning environments are settings where a child spends most of his/her time, such as at home or nursery. No matter the family structure, family life will largely consist of routines that are repeated at similar times each day (Segal, 2004). By participating in daily family routines, children aged 0-5 years old learn to become independent in self-care, start to understand family routines, develop positive interactions between family members and increase a sense of belonging and identity (Segal, 2004; Fiese, Hooker, Kotary, & Schwagler, 1993; Boyce, Jensen, James & Peacock, 1983). Delivering therapy in the child’s natural setting promotes learning opportunities within the child’s daily routines. Therefore, caregivers can support their child within repeated naturally occurring opportunities, such as during mealtimes and getting dressed, resulting in multiple opportunities to develop skills (Cheslock & Kahn, 2011; Bruder, 2010; Howe, 2008; Campbell & Sawyer, 2007; Dunst et al., 2001; Dunst, Hamby, Trivette, Raab & Bruder 2000). UK Early Year’s Speech and Language Therapists (SLT’s) acknowledge the importance of the caregiver’s role in helping children learn and generalise skills to other activities/routines, settings and communication partners (Roberts & Kaiser, 2011; Pickstone, Goldbart, Marshall, Rees & Roulstone, 2009; Baxendale & Hesketh, 2003; Law, Garrett & Nye, 2003; Girolametto, Pearce & Weitzman, 1996; Gibbard, 1994). SLT’s also recognise that greater parental involvement in home practice leads to better outcomes for the child (Guimond, Wilcox, & Lamorey, 2008; Watts Pappas, McLeod, McAllister & McKinnon, 2008; Girolametto & Weitzman, 2006; Kashinath, Woods, & Goldstein, 2006). However, typically in the UK, services are delivered in the clinic setting (Watts Pappas, McLeod, McAllister & McKinnon, 2008). For example, the Bercow report (2008) found that services supporting children with Speech Language and
Communication Needs (SLCN) are often designed to support the needs of the Local Authority rather than the needs of the family (Klatt & Roulstone, 2016). The pathways and waiting lists in organisations have been found to largely determine the structure of therapy rather than individualising therapy to the needs of the family (Klatt & Roulstone, 2016).

In summary, evidence suggests that promoting child participation within daily routines allows for regular motivating learning opportunities to occur each day for the child. In the UK SLT services are typically based in a clinic setting and therefore UK therapists usually encourage parents to transfer the skills from clinic to home with varying success.

2.1.3 Coaching

Building the caregivers’ skills and confidence is crucial in supporting their child’s needs. Lower parental satisfaction levels were reported when parents felt their specific knowledge of their child’s activity limitations and participation restrictions was overlooked by health professionals (Edwards, Brebner, McCormack, MacDougall, 2016; Robert, Leblanc & Boyer, 2014; McCormack, McLeod, Harrison & McAllister, 2010). Parental satisfaction was reported to be higher when the clinician and parent worked in collaboration to develop therapy management plans resulting in better outcomes for the child (Carroll, 2010). Typically in the UK, Speech and Language therapy services are delivered using a child-centred approach in which clinicians are viewed as the expert. In the child-centred approach, the clinician assesses the child’s difficulties, identifies areas of concern, recommends interventions, develops goals around developmental skills and monitors/measures progress (Peacock, Konrad, Watson, Nickel & Muhajarine, 2013). The parents are usually included as observers in clinical sessions and supervisors of home practice to varying degrees (McKean, Philips,
Thompson, 2012; Watts Pappas, McLeod, McAllister & McKinnon, 2008; Campbell & Sawyer, 2007).

Certain Early Years health professionals in the USA use ‘coaching’, a technique in which the clinician promotes the caregivers’ ability to support their child’s needs during and between every intervention visit. The five coaching characteristics used by health professionals and which will be discussed in more detail later in the report are: joint planning, observation, action/practice, reflection and feedback (Rush & Shelden, 2011; Woods, Wilcox, Friedman & Murch, 2011; Kaiser & Hancock, 2003). Coaching aims to facilitate the family’s participation in the decision-making and planning of the intervention activities for their child (Rush & Shelden, 2011). The health professional guides the family in identifying difficulties within their daily routine such as, feeding, sleeping (McWilliam, Casey & Sims, 2012). The health professional then works with the child’s family to enhance the families’ capacity to support their child’s learning and development within the identified activities, such as playtime, mealtime, bedtime (Dirks & Hadders-Algra, 2011; Hadder-Algra, 2011; Peterson, Luze, Eshbaugh, Jeon & Kantz, 2007; Rush, Shelden & Hanft, 2003). As a result, caregivers have been found to more readily implement therapy management plans in everyday routines when the plan reflects their goals for their child and when they feel more confident in their own capabilities (Bruder, 2010; Watts Pappas, McLeod, McAllister & McKinnon, 2009; Crais, Poston Roy & Free, 2006; Moxley-Hargeart & Serbin 1983).

In summary, for the UK to facilitate the shift from being professional led to joint-working with the family, health professionals would need to integrate their evidence-based interventions and use coaching techniques to equip caregivers to promote child participation in their daily routines (Hadders-Algra, 2011; Woods, Wilcox, Friedman & Murch, 2011; Peterson, Luze, Eshbaugh, Jeon & Kantz, 2007).
2.1.4 Primary Service Provider approach to teaming

The third component of the service delivery model used in 28 states of the USA use some form of Primary Service Provider approach to teaming. Increased demands placed on families to meet their child’s health needs can impact on family life (Whiting, 2013; Heaton, Noyes, Sloper & Shah, 2005; Roberts & Lawton, 2001). A UK parent survey found that parents who attend multiple appointments with their child reported they prioritise one appointment over another and felt that appointments would feel more manageable as the child gets older and the appointments start to become part of their routine (Touch & Berg, 2016). The findings support a reported increase in non-attendance of appointments associated with younger children and children with developmental delay/disorders (Stathopulu, Ajetunmobi & Selling, 2003). The impact on services due to the non-attendance, typically known as ‘Did Not Attend’ (DNA), has been found to result in longer waiting times, decreased client satisfaction and inefficient use of NHS resources (Cameron et al., 2014; Bech, 2005; Pesata, Pallija & Webb, 1999). The family-centred approach used in 28 States in the USA involves one health professional, such as a SLT, Occupational Therapist, Physiotherapist or Educator, who provides support, resources, and information to the child and family during regular home visits and/or visits to local community settings (Sukkar, 2013). Each Primary Service Provider is supported by a team of professionals from a variety of disciplines who provide additional support to the child and family as required (Shelden & Rush, 2013). The researcher observed multi-disciplinary teams made up of; Speech and Language Pathologists, Physiotherapists, Occupational Therapists, Nurses, Clinical Psychologist and Early Years teachers. This approach has been found to; better meet families’ needs, be a more comprehensive and efficient intervention service and less
intrusive in the family’s life (King et al., 2009; Hanson & Bruder, 2001; Bruder, 2000; Sloper, 1999; Sloper & Turner, 1992).

In summary, using the Primary Service Provider teaming approach reduces the number of additional appointments the family attends which in turn reduces the pressure on family life and routines. As a result, non-attendance rates decrease as parent participation increases making services more efficient while better meeting the child/family’s needs and the needs of the local authority.

2.2 Research Questions

The literature on natural learning environments, coaching and the Primary Service Provider approach to teaming formed the basis for the current research project. This project investigated the model and considered applications for therapy services in the UK’s National Health Service (NHS). This report will address the following aims:

2.2.1 Aims of Project

1. To investigate a family-centred approach to service delivery comprising of a three component service delivery model collectively known as ‘evidence-based practices in early childhood intervention’ used in government funded centres in the USA.

2. To compare the family-centred model of service delivery with the UK child-centred, clinic based service delivery model.

3. To share findings from the USA service delivery models with UK counterparts.
Project Objectives

1. Observe and shadow teams carrying out the family-centred model of service delivery in the USA.

2. Discuss with service providers, practitioners and parents their experience of implementing or receiving speech and language therapies within the family-centred three component service delivery model.

3. Discuss with service providers how they transitioned and implemented the family-centred, three component service delivery model in their State.

4. Compare and contrast the family-centred model with our child-centred, clinic based service delivery model.

5. Present findings from the USA to UK counterparts to influence the current drive to redesign Early Years Speech and Language Therapy (SLT) services within the NHS.
3 Case Studies

The following case studies exemplify the key aspects of the team meetings and the three component service delivery model across a range of family structures, socio-economic backgrounds and diagnoses. The case studies are based on the researcher’s observations at home visits, which were led by a variety of professionals. To protect confidentiality, the case studies have been anonymised by using pseudonyms and all identifiable information removed. First is a short section on team meetings, which underpin and set the context for the subsequent case studies.

3.1.1 Team Meeting

Time taken for team meetings is costly to programs both in the UK and USA. The team at FIPP responded to the need to have efficient and effective team meetings by developing tools based on literature on effective teaming characteristics (Larsson, 2000; Holpp 1999; Weaver & Farrell, 1997; Kayser, 1994; Daniels, 1990; Doyle & Straus, 1982). Team meetings, in the family-centred approach, are where the PSP is chosen for new families, current families are discussed and an opportunity for colleague-to-colleague coaching and support is provided. All team members are expected to attend the meetings which are hosted by a skilled facilitator and take place for 90 minutes, once a week, at the same time/day and location (Shelden & Rush, 2013).

3.1.2 Referring into the program

Children are referred into the program by health professionals or the caregivers themselves. Next, an evaluation is carried out within the child’s home to ascertain whether the child is eligible for the service. Children who automatically are eligible for the service are children who have a diagnosis. The evaluation is conducted by two members of the team, one of who may be the likely PSP. The team member has a conversation with caregivers about the family, routines, activity settings, child interests
and resources needed by the family. A ‘most likely’ PSP is identified at a team meeting, using the methods described in the paragraph below. The program has 45 days to determine eligibility, develop the Individualised Family Service Plan (IFSP) and start intervention. From the information gathered in the evaluation the PSP talks with the caregivers about everyday situations to identify their priorities and create IFSP outcomes using tools, such as but not limited to, the Routines Based Interview (McWilliam, Casey & Sims, 2009). The practitioner also observes a real-life activity by initially taking a passive role to observe how the situation typically occurs. The child’s current level of participation is assessed as well as the caregiver’s interactions with the child during the activity. IFSP outcomes are then discussed and jointly set with the caregivers and the PSP (Shelden & Rush, 2013).

3.1.3 Choosing the Primary Service Provider

In each case study a PSP will be referred to. Transcript 1 is an example from a team meeting in Texas in which a PSP was chosen for a newly referred child. A clinician presented the child’s case information, including the child’s background history and family’s priorities, gathered from an initial assessment, called an evaluation, which took place in the family home. A worksheet comprising of three tiers (see appendix 1.1. FIPP Casetools: Worksheet for selecting the most likely Primary Service Provider) was used by the clinician to efficiently and effectively communicate the information from the evaluation. The process filtered the entire team down through the three tiers in order for a Primary Service Provider to be selected as a ‘best fit’ for the family (Shelden & Rush, 2013). The case presentation and choosing the PSP took around 5-10 minutes.
Transcript 1

Clinician: Jason is 2 years and 3 months old. He lives with his foster mom with three dogs and a cat. The foster mom’s priorities are that she would like Jason to communicate his needs and Jason to participate in bedtime routine. Jason likes tickles, affirmation, playing outside on the trampoline and swings. The PSP’s knowledge and expertise... they need to be familiar with foster kids, knowledge of a two year old and be okay with dogs.

Meeting Facilitator: Any potential PSP’s? [six people raised their hands]

Clinician: (continued to second tier) Safety... the PSP needs to have a car that is okay with rocky tracks and dogs... the family live in the [geographical area].

Meeting Facilitator: Any potential PSP’s? [two people from original group raise their hands]

Clinician: (continues to next tier) Foster mom is available Mondays, Tuesdays and Thursdays after 12:30 as she has shifts at the local grocery store.

The two remaining PSP’s explained why they were interested in being the child’s PSP and identified support they may need from the team, in order to support the family. The chosen PSP then booked in the first session.

The researcher observed that the advantage of using the tier model was that the child’s case was presented succinctly, the worksheet also removed the indecision of choosing a team member at the possible cost of offending another team member.
3.1.4 Peer support

Reference to the Primary Coaching Opportunities (PCO) are also present in the case studies, which are opportunities for the PSP’s to receive support and learning. Around 10-20 minutes per PCO is allocated. The team member attends the meeting with a clearly defined question and an idea of the type of support he/she is seeking from team members. For example in case study three and five both PSPs attended the team meeting with a Primary Coaching Opportunity; case study three’s PSP seeks advice and support around feeding whereas case study five’s PSP query was around communication development. The team then uses coaching, see 3.3 Coaching, for more detail on coaching, to support the team member and as a result, all the disciplines represented at the team meeting learn from the question/answers provided.

3.1.5 Caseloads

In addition to selecting a PSP and peer support, the team meetings provide an opportunity for the team to be up-to-date with the caseload. The researcher observed teams who served large caseloads using the family-centred approach to service delivery. For example, 20 teams comprising of approximately 300 staff serve on average 3,900 children per day and 10,000 children per year in 11 counties in Texas. An average team member works an 8 hour day which comprises of 5 hours of direct service, 1 hour of case management (administrative tasks) and 2 hours of travel time. 80% of planned visits are delivered and if families do not attend appointments then the PSP and family have a discussion to problem solve the perceived barriers to their attendance. The family then receives a letter, if they continue to not attend appointments, explaining they have 14 days to contact the service otherwise their child will be discharged. At team meetings, time is allocated during the meeting for quarterly updates of current children, children leaving the program or transitioning to school aged
services. The PSP provides information to the team about the family they are seeing quarterly so the entire team are up to date with the family and the family receive input from the multi-disciplinary team. For example, in case study three, the Primary Coaching Opportunity arises from presenting information at the quarterly report. The information consists of; a brief overview of the current plan, status of the plan and next steps. Names of children leaving the program are also printed on the agenda.

3.1.6 Participation Interaction Style

Team members used a coaching style of communication which underpinned the entire meeting in order for team members to support learning opportunities and to share information. The researcher noticed that the communication style of coaching resulted in:

- Information being efficiently shared during the meeting, for example, ‘Is it nice to know or need to know?’
- Higher accountability amongst team members, for example team members recognise when they need support from other team members.
- Team members using coaching rather than ‘advice giving’ in response to queries. For example instead of using ‘you should/ ought to/ need to’ team members would say, ‘What have you tried already?’, ‘How did that work?’, ‘Have you considered using [strategy]?’. Similarly, difficult behaviours amongst team members were challenged in a constructive manner using coaching rather than letting the behaviours go unchecked, which can cause further problems.
Agreed team meeting rules were referred to if the meeting rules were breached. For example the researcher observed the facilitator, at one team meeting, challenge team members to consider whether they would feel comfortable continuing to talk about families in the current way if the families were sitting around the table during the meeting.

In summary, team meetings efficiently assign clinicians to children, monitor team caseloads and supports peer learning.

3.2 Natural Learning Environment Practices

The following two case studies demonstrate how clinicians use the child’s natural learning environment to meet the child’s developmental needs. Case study one demonstrates how a Speech and Language Pathologist in the USA uses a child’s home setting to meet her functional communication goals. Case study two exemplifies functional goal setting. The example is of a child with Autism Spectrum Disorder (ASD) but the same principles apply with all children accessing the three component family-centred model.

Case study 1: Meghan

Meghan* is 2 years and 6 months old and presents with a language delay. Meghan lives at home with her mother, father, and younger sister. The researcher visited Meghan’s home in a rural area in the Mid-West with the Speech and Language Pathologist (SLP). Meghan was present with her mother and younger sister at the visit.

Meghan’s functional goal, observed during the visit:

- Meghan will make food choices by pointing or using words to tell her caregivers what she wants at meal time.
Prior to the observed home visit, the SLP and Meghan’s mother had agreed the visit should take place during ‘juice-time’. Juice-time was a highly motivating activity for Meghan and a typical activity which took place several times during the day. The SLP asked the mother to carry out ‘juice-time’ as she typically would as if the SLP was not present. The mother opened the fridge, took out the juice, and poured it into Meghan’s cup without talking to Meghan. The SLP asked Meghan’s mother how she could model for Meghan what she wants her to say. Meghan’s mother said, ‘I dunno really…err…. I dunno’. The SLP then asked ‘Can I make a suggestion?’ and suggested to the mother what he would like her to try. For example, Meghan’s mother could use the word ‘open’ as she guides Meghan’s hand to the fridge door handle. The SLP showed Meghan’s mother how to do this then Meghan’s mother immediately was invited to try. This is known as ‘intentional modelling’ in which parents are asked to watch the coach demonstrate a technique and then are immediately provided with an opportunity to try. The SLP asked the mother ‘what do you think about that?’, Meghan’s mother replied that she felt this worked well. Next, Meghan’s mother and the coach came up with another idea in which the mother provided Meghan with two options of drinks and named each drink. The SLP asked what the mother thought about the strategies, ‘What do you think about that?’ and the mother agreed she thought it was a good idea and “Makes sense”. At the end of the session, the mother reported “I feel more confident helping my daughter this week”. The case study supports evidence from Randomised Control Trials (RCT) which found
that parents reported the family-centred approach is more functional for their child and they felt more confident and involved in supporting their child (McKean, Phillips & Thompson, 2012; Moxley-Haegert & Serbin, 1983). At the end of the visit, the SLP and mother agreed that the she would practise the strategies during ‘juice-time’ during that week and agreed the next session would take place at 16:30 to explore opportunities to make choices during dinnertime.

**Case Study 2: Carla**

Carla* is aged 2 years and 9 months and was recently diagnosed with Autism Spectrum Disorder (ASD). Children with ASD are commonly recognised to experience challenges around daily routines such as during mealtimes and bedtime, often as a result of self-directed and/or sensory processing difficulties (Marquenie, Rodger, Mangohig & Cronin, 2011; Larsson, 2006; Werner DeGrace, 2004). The researcher visited Carla’s home with a Speech and Language Pathologist (SLP). Carla lives at home with her mother, father, two dogs and a cat in a residential area in the Southern States. The researcher attended a session where the SLP was reviewing Carla’s goals on her ‘Individualised Family Service Plan’ known as an IFSP. The IFSP outcomes comprise of functional, participation-based goals for the child. The goals, known as IFSP outcome statements, are based on identified priorities of the family and are reviewed regularly, at least every six months. The outcomes reflect what the family would like to occur and identify the expected result. The success of the goals is measured by parents at key life points such as, birthdays or culturally relevant life events. These markers are more meaningful to parents than a time frame and supports caregivers in measuring success within the context of their family life (Shelden & Rush, 2013). The statements are worded to be meaningful to caregivers, positive statements that are action oriented and indicate changes the family wants to see rather
than a description of the deficit/needs of the child (Shelden & Rush, 2013). For example, Carla’s family had previously identified that they struggled to leave the house with Carla as she becomes distressed which puts pressure on the family. Carla’s parents also reported they felt Carla did not understand simple instructions. The SLP explained to the researcher, that to make traditional therapy goals such as; ‘Carla to follow one key word level instructions by the end of the therapy block’ more functional she asks herself ‘why is Carla needing to following one word instructions?’ and ‘when is it useful for Carla to follow one part instructions?’. Therefore, based on family report and the IFSP guidelines the SLP and family agreed the following IFSP outcome:

- By her third birthday, Carla will find and bring her parents her shoes when given a simple direction before leaving the house at least two times each day every day for one week.

As a result, Carla’s IFSP outcome statement includes following instructions but the skill is part of the activity of collecting and putting her shoes on when the family leave the house. The mother reported to the researcher that the goals set by the SLP “... are goals I can work on everyday rather than just a pass or fail on one day in a therapy session”. The mother’s view is supported by current research, which indicates better outcomes for children with ASD where parents and therapists collaborate to plan, deliver and evaluate intervention within a family-centred model (Edwards, Brebner, McCormack & MacDougall, 2016; Hanna & Rodger, 2002). To achieve the goal, the SLP booked visits when an opportunity arose during the family’s daily routine for Carla to put her shoes on, for example, to go outside to the garden or to the car. The SLP, during the sessions, may also joint problem solve with the parents to develop visual
support for Carla, such as a ‘first/next’ board or a visual timetable for leaving the house. Beatson & Prelock (2002) suggest that family-centred care is particularly suited to ASD as occasions where the child finds social interaction and communication difficult can be practised and supported within the actual context rather than replication within a clinic setting (Keen, Couzens, Muspratt & Rodger, 2010; McCoanchie & Diggle, 2007; De Greeter, Poppes & Vlaskamp, 2002).

In summary, natural learning environments can make intervention functional and clinicians use family routines, household items and toys which are familiar and available to the child.

3.3 Coaching

The following two case studies demonstrate how clinicians use a communication style called coaching. Case study three demonstrates how clinicians coach each other on joint visits and coach the caregiver. Case study four exemplifies a clinician coaching a staff member in a childcare setting.

Case study 3: Marleigh

Marleigh* is 16 months old and lives at home in a rural area in the Mid-West with an elderly relative, who is her main caregiver as her parents are absent. Marleigh has dysgenesis of the corpus callosum, decreased white matter overall, a previous prenatal cyst, low muscle tone, growth hormone deficiency (for which she receives a steroid supplement), bilaterally blocked tear ducts, and gaze-evoked nystagmus. When developing her IFSP outcomes the main caregiver reported to the Physiotherapist (PT), Marleigh’s PSP, that she wanted Marleigh to move independently, eat the same foods as the rest of the family and communicate her needs particularly during play and
mealtime. Therefore the PT and the caregiver jointly agreed the following IFSP outcomes:

- Marleigh will call for caregivers when she needs or wants something during play.
- Marleigh will come to a caregiver when called.
- Marleigh will get toys off the coffee table during playtime without help.

Prior to the researcher’s visit the PT presented Marleigh’s quarterly report at a team meeting to review Marleigh’s outcomes with the team. The PT reported that the main caregiver felt Marleigh’s eating was atypical. The PT reported that following a joint discussion around Marleigh’s eating the caregiver and the PT had agreed to seek support from another professional with the possibility of a joint visit. At the team meeting team members suggested the Occupational Therapist (OT) would be most appropriate to support the PT and the family on a joint visit.

*Joint planning meeting*

Prior to the home visit, the PT and OT planned the visit using the joint planning tool *(see 8.3 FIPP Case tools: Joint Planning Tool)*. The purpose of the joint planning meeting is to agree on each professional’s role and activity settings and goals during the visit. During the meeting, observed by the researcher, the PT and OT agreed two activities to observe during the visit;

1. Marleigh transitioning to and from the kitchen.
2. Marleigh eating at lunchtime.

The PT and OT agreed the following roles:
• PT to initiate the conversation with the family (reviewing previous plan, etc) and talk about the transitions to and from the kitchen.

• PT to facilitate general questions about learning and how the activity of mealtime was going and would ask the OT questions to clarify aspects of mealtime.

• The OT and PT jointly agreed that the OT would comment on the caregivers actions during meal times and answer the PT’s questions to help coach both the PT and caregiver.

*The home visit*

The visit observed by the researcher took place in the caregiver’s home at lunchtime. The caregiver walked Marleigh by the hands to the kitchen and as she did so the PT took the opportunity to offer coaching. The PT asked the caregiver “how much support is she receiving from you right now?”, the caregiver replied “a lot”. The PT asked “how could you make it a little more challenging for her?” as the caregiver continued to walk Marleigh to the kitchen she replied “…by holding her by one hand?” which the caregiver tried and Marleigh sat down on the floor unable to continue walking. The PT asked “Can I make a suggestion? Could you try holding her hand downwards so she has less support from you?” The caregiver replied “ah I see, that’s making it harder for her but she’s still doing it!”. The OT and PT sat beside the caregiver in the kitchen, with Marleigh in the highchair and the caregiver feeding Marleigh. The caregiver gave Marleigh a drink, she took a couple of sips and dropped it to the floor. The caregiver repeatedly picked up the drink and placed it on Marleigh’s highchair. The OT asked a coaching question, “what you do you think she is telling you?” the caregiver replied “I think she is saying she is done.” In addition, Marleigh started to rub her face and turn
her face away while the caregiver was trying to feed her. The OT asked another coaching question, “why do you think she does that?” caregiver replied, “she needs a break”. Furthermore, the OT commented on the caregiver’s actions, “what I am noticing is she is controlling the food better with those finger foods and taking the spoon herself”. In these examples the OT and PT used coaching questions and comments to build the caregivers capacity which means the caregiver is more likely to recognise these communication cues in future.

The debrief

The PT and OT kindly constructed the following transcript (transcript 2) of their debrief meeting following the joint visit. The OT uses coaching questions to evaluate the usefulness of her support for the PT, for example, ‘How helpful was the information I provided during the visit?’ and help her understand how the PT will use the information provided during the session to help support the family in future. For example, the OT provided advice around cup size, so asked the PT, ‘What is your plan around following up with that?’. Furthermore, the clinicians coach each other on their roles during the visit, which allows regular peer support through reflective practice, for example, ‘How did you feel about our debrief with the caregiver?’. The researcher observed that peer coaching appeared to result in openness between team members to recognise when they needed support and team members reflected on their own professional and clinical skills in a constructive and supportive manner.
Transcript 2: The PT and OT’s debriefing conversation following the joint session.

**PT:** So how do you feel that went, generally?

**OT:** I was excited that she did take some bites from the spoon, and she’s definitely exploring the food a little more. How helpful was the information I provided during the visit?

**PT:** It was helpful for me to see how much things like plates and cups and spoons matter in setting the environment for her to be ready to eat. I also think it was good to have your feedback when she seemed to be choking a little with the cup. It seemed to me like it got better after the change, is that accurate?

**OT:** Yes. She was getting too much liquid from the larger cup. What is your plan around following up with that?

**PT:** I am going to ask the next time I go to make sure everyone understands the signs that they might need a slower-flow cup and ask how the new cup has been working.

**OT:** How well did you feel that we stuck to our roles?

**PT:** I was very comfortable with how things went. I think the places you jumped in were very appropriate, and you consistently let me take back the lead of the visit when you had shared what you needed to.

**OT:** And what are you planning to do differently based on the conversations we had?

**PT:** I liked the information about letting her play with her food with her hands. I had an idea that was important, but you emphasized it more, which helps me know how to address feeding going forward.

**OT:** What do you think worked about that?
PT: Maybe making everything less stressful?

OT: Yes, I think that’s exactly it. We want her to enjoy mealtime and not feel stressed.

PT: It’s hard for me to know how much to push eating, since it is so important. I liked that you shared the Division of Responsibility in Feeding with me, and I think I can keep using that.

OT: Great. How did you feel about our debrief with the caregiver?

PT: She seemed happy with what we got from you and confident about the plan we made together. She’s the kind who would tell us if there was something that made her uncomfortable.

OT: Okay, so, when do you want me back?

PT: Well I know you are on the plan for once a month, but if you think we need it sooner we can look at that.

OT: I think that is fine. She is not unsafe when eating, it’s just strategies to make her more independent.

PT: So I will plan to let you know when we schedule another mealtime visit, probably in around a month.

OT: Sounds great.

3.3.1 Coaching in Nursery Settings

Early Years Practitioners have the potential to improve the child’s developmental outcomes particularly when the child accesses daycare for a large proportion of the child’s day (Pickstone, Goldbart, Marshall, Rees & Roulstone, 2009). A study compared six methods of providing early intervention in child care settings over 2 years
with 80 children. Results indicated that using coaching practices and embedding intervention within the child’s routine was found to be easier for EYP’s to practise which meant that intervention was occurring between visits (Hughes-Scholes, Gatt, Davis, Mahar & Gavidia-Payne, 2016). Therefore, coaching practices are used within the family-centred approach to build the EYP’s capacity to support the child’s needs (Rush & Shelden, 2011). The case study below provides an example of a health professional providing coaching to an Early Years Practitioner (EYP) in childcare setting in the Mid-West.

**Case study 4: Tyler**

Tyler is a 30 month old attending a nursery five days a week. The researcher visited the nursery with the Early Childhood Special Educator (ECSE). The ECSE provided coaching for the child care provider about how to support Tyler.

Tyler’s IFSP outcome:

- Tyler will use words and gestures to request food/drink during meal times.

The researcher and ECSE observed Tyler during lunchtime with six peers. The ECSE sat with Tyler during the meal time and coached the child-care provider to wait for Tyler to respond with sign, gesture or vocalisation when she asks Tyler a question or instruction. For example during lunch time, giving choices of food items, modelling signs for foods, slowing her speech rate and modelling simple request phrases. The EYP reported: “the strategies do not feel like an extra chore because (the ECSE) coaches me to support
(Tyler’s) needs in his everyday routines within day-care and so there are loads of times in the day to practice”. In addition, the EYP reported that she can extend the knowledge she has gained to other children within her care. The researcher observed that coaching required more flexibility in child-care settings as the staff member had more pressures on their time. The ECSE jointly worked with the child-care provider to choose the best time for both the child-care provider and to observe Tyler in his activity.

In summary, coaching can be used to build capacity of caregivers, fellow team members and Early Years Practitioners to better support a child’s health needs.

3.4 Primary Service Provider Approach to Teaming

Primary Service Providers (PSP) request assistance at team meetings to provide additional support to the child and family as required. In the following case study the SLP is the Secondary Service Provider (SSP) by providing assistance to the ‘Birth to Kindergarten Teacher’ who is the family’s Primary Service Provider (PSP), known here on in as ‘teacher’.

Case study 5: Juan

Juan is 2 years and 11 months old and presents with a language delay. Juan lives in a mobile home in a small town in the Mid-West with his mother and two older sisters. Juan and his family are ‘Hispanic’ a term that refers to native Spanish-speaking and Spanish decent individuals who reside in the USA. Children of Hispanic descent represent 21.4% of the early years population and comprise of the largest ethnic group to receive speech and language therapy services (Kummerer, 2012).

Juan’s mother had previously reported to the teacher (Juan’s PSP) that Juan was not speaking clearly in both English and Spanish and asked the teacher for a SLP to provide
support. The teacher, Juan’s PSP, presented Juan’s profile at one of the weekly team meetings and an SLP was chosen to support the teacher, Juan and his family. The IFSP outcomes can either be child or family focused, the IFSP outcome below is an example of a family focused outcome statement:

- Juan’s mother will learn to support Juan’s communication and articulatory intelligibility during story time.

The Joint Planning Meeting

Prior to the visit the teacher had discussed with Juan’s mother her questions, anticipated outcomes and specific actions expected from the SLP’s upcoming visit. The researcher observed the subsequent joint planning meeting between the SLP and teacher (see 8.3 FIPP Case tools: Joint Planning Tool). At the joint meeting, which lasted around 15 minutes, the teacher shared with the SLP the background information, including Juan’s interests and activity settings, and reason for the visit. The agreed activity for the visit was for the mother to read a book with Juan. The SLP and teacher then agreed their roles for the upcoming visit, see below:

- Teacher (PSP), will lead as the coach during the first part of the visit to assess the family's current use of strategies taught in the previous therapy session.

- SLP (acting as SSP), will introduce and model strategies such as expansion and extension during story time and incorporate short-term memory recall strategies for the teacher and parent to immediately try.
The teacher agreed to take the lead with the SLP observing and supporting, sharing information and modelling when appropriate with the PSP and parent.

*The Home Visit*

At the joint visit, the researcher observed the mother reading, ‘The Hungry Caterpillar’ to Juan and his two older sisters. Juan’s family had few toys in the trailer and the book had been borrowed from school by the older sister. The teacher began the session by asking Juan’s mother an open ended question, ‘What does story time typically look like? Please show me’, the question invited the mother to show the teacher what she was already doing and informed the teacher where the mother needed support. The mother reported that Juan and his older sisters all enjoy having story time together but the sisters can be distracting for Juan. The teacher encouraged Juan’s mother to show her their typical routine rather than the ideal scenario of a distraction-free environment. The mother sat on the sofa, with the three children sat on the floor. The teacher and SLP sat nearby and observed the mother reading the book to her children using the strategies the teacher had previously discussed, such as helping Juan to self-adjust his sitting posture to enhance joint attention. The researcher observed the SLP using the *seven step process to modelling*, which are seven steps the professional uses to make modelling to caregivers intentional, direct and specific rather than ‘hopeful modelling’ in which the clinician hopes the parent will see and do what works (Rush & Shelden, 2011). The SLP and teacher explained to Juan’s mother that the SLP will observe the story time to ascertain some strategies that may be useful for Juan’s mother. After a couple of pages the SLP had noticed Juan’s mother was asking test questions of Juan, for example pointing to a picture and asking ‘What’s this?’. The SLP first asked the mother permission to provide her with some information. For example, the SLP asked, ‘Can I make a suggestion?’ the mother agreed and the SLP started to briefly explain the
strategy he was introducing, so Juan’s mother had a specific strategy to observe. The SLP then demonstrated the strategy, for example pointing to items in the book and commenting on the pictures. The SLP then debriefed with the mother and discussed briefly how the story time with the strategies may look the same or different to what she currently does. Immediately following the mothers attempt to carry out the suggested strategy the SLP and Juan’s mother reflected on the activity, ‘How well did it work for you?’. The purpose of this is to help Juan’s mother be more motivated to use a strategy which she feels is useful, works and for her to feel confident in using in everyday routines when the therapist is not present. At the end of the session the teacher and SLP debriefed with the parent and agreed a plan of when the strategies introduced will happen in their natural routine. The teacher also agreed the following weeks plan, activity (eg. mealtimes) and time of session to suit the activity (ie. lunchtime).

*The debrief*

The teacher and SLP debriefed back at the office by revisiting the joint planning tool of agreed outcomes for the visit. Both professionals debriefed using reflective questions, such as, to evaluate the session, ‘*What worked well in this session?*’, evaluate the strategies used, ‘*How will you incorporate these new strategies into activity settings following this visit?*’ and agree future management, ‘*How will you know if these strategies continue to support the child’s learning?*’. For example the teacher asked the SLP to evaluate her role in the joint visit by asking, “*How can I do things differently?*”. The SLP suggested that the teacher could request the SLP for more feedback during the session to support her learning. The researcher observed that the debriefing questions supported daily reflective practice following sessions, increased accountability between
team members and increased understanding of other professional’s roles within the team.

In summary, joint visits involve a joint planning meeting, joint visit and debrief in order for the PSP and SSP to work effectively and efficiently together and thereby best meet the needs of the family.
4 Caregiver Survey Results

The next section summarises the results from surveys used to measure caregiver satisfaction of receiving intervention in one of the following three settings; UK NHS clinic, USA private clinics or programs using natural learning environment practices, PSP and coaching.

4.1 Methods

4.1.1 Participants

A total of 125 completed surveys were collected from caregivers in the UK and USA. The total responses from caregivers comprised of 82 boys and 43 girls. 41 responses were received from three NHS clinics in Central London. The children’s ages ranged from 21 months to 4 years and 7 months. 56 responses were received from six Early Intervention programs in Kansas, MRMH Tarrant County, Fort Worth, Texas and Family, Infant, Pre-school Program (FIPP), in Morganton, North Carolina. The children’s ages ranged from 4 months old to 3 years old. 28 responses were received from two private clinics in Austin, Texas called Capital Therapy Group and Little Tesoros Therapy Services. The participants’ ages ranged from 2 to 28 years old. See table one, for overall description of service delivery of each clinic/program. See appendix 8.1 Programs Visited in the USA for more information on each clinic/program.
Table 1 Summary of service delivery models based on observations from two private clinics in Texas, Early Intervention programs in North Carolina, Texas and Kansas and three NHS clinics in Central London.

<table>
<thead>
<tr>
<th></th>
<th>Two private clinics in Texas</th>
<th>USA Family-centred approaches</th>
<th>UK NHS clinics in Central London</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funding</strong></td>
<td>Health Insurance</td>
<td>State funded, public and private health insurance, no-one refused services.</td>
<td>Government funded, free to all families.</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Purpose built centre with SLT, PT and OT present. Infrequent use of joint sessions due to insurance limitations.</td>
<td>Child’s Natural Setting eg. Home, day-care. Joint visits between early intervention professionals.</td>
<td>Speech and Language Therapy clinic in the child’s local area.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Written for insurers to measure success. <em>Combine simple two word phrases together in 6/10 opportunities with moderate verbal cues</em></td>
<td>Written for parents to measure success. <em>(Child) ask for help to open food items at dinner time by her second birthday</em></td>
<td>Written for parents and NHS outcome measures. <em>(Child) will use two words together once during the therapy session by the end of the therapy block.</em></td>
</tr>
<tr>
<td><strong>Example of a goal for a child whose aim is two use two words together.</strong> <em>(The goals are typical of clinics observed, however the author accepts there may be variation between professionals).</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parent participation</strong></td>
<td>Parents not typically present in sessions.</td>
<td>Parents are the main person involved in the session with the child.</td>
<td>Therapist leads the session with parents typically taking on observer role.</td>
</tr>
</tbody>
</table>
4.1.2 Data

Caregivers were asked to rate their level of satisfaction on a five point Likert scale on topics such as; level of involvement during sessions, logistics of sessions and implementing practice between visits. The survey also consisted of two sets of qualitative data in which parents were provided with the opportunity to write the strategies/activities they use to support their child and further suggestions to improve service delivery. The survey was distributed via email or by hand by the researcher or participating clinicians.

4.1.3 Analysis

Five themes were identified from the questions developed for the survey and the responses from the surveys were then collated and inputted into an excel spreadsheet. Graphs were produced for each theme to create visual examples of data trends. Qualitative data produced from the comment sections was put into a table, the responses on the types of activities/strategies caregivers were colour coded by the researcher using three themes: 1) parent-child interaction (PCI) type strategies, 2) activities requiring specific tools/materials and 3) strategies used within the routines. The three themes were compared across the three settings; USA private clinics, USA family-centred approach and UK NHS Speech and Language Therapy clinics. For the following presentation of results, key examples were identified to best exemplify each theme in analysis.
4.2 Results

Caregiver satisfaction results in the present data can be summarised as the following five themes:

1. Caregiver participation
2. Transfer of skills from the session to daily routine
3. Multiple appointments and the impact on family life
4. Perceived level of clinician skill and expertise
5. Overall comments

4.3 Caregiver Survey Themes

4.3.1 Caregiver Participation

Typically in the UK, SLT’s are predominantly the leader of the activity with the caregiver most often acting as an observer. In family-centred visits, the caregiver directly interacts with the child and the therapist’s most frequent role is as facilitator (Watts Pappas, McLeod, McAllister & McKinnon, 2008). Evidence suggests that greater caregiver involvement in home practice leads to better outcomes for the child (Guimond, Wilcox, & Lamorey, 2008; Girolametto & Weitzman, 2006; Kashinath, Woods, & Goldstein, 2006). Based on the literature, caregivers in the UK and USA were asked the following questions:

- How often are you the main person involved in the activities during the therapy sessions with your child?
- How often is the therapist the main person involved in the activities during the therapy sessions with your child?
Graph 1 and 2 show the caregiver’s responses in USA private clinics, USA family-centred and UK NHS Clinics.

**Graph 1** The level of caregiver involvement in sessions across the three settings

**Graph 2** The level of clinician involvement in sessions across the three settings
Responses from three UK NHS clinics indicate that caregivers perceive the therapist as being the main person involved during sessions with their child. The results follow a similar trend as caregivers attending USA private clinics who are not present during sessions. By contrast, caregivers receiving the family-centred approach reported they are the main person involved with their child during intervention sessions and the clinician was less involved. The results indicate that caregivers in the UK, who participated in the survey, perceived themselves as less active participants in therapy sessions. The family-centred model results indicate that coaching increases parent participation. Evidence suggests greater parental involvement results in improved outcomes for the child (Dunst & Trivette, 1996). Therefore, the survey results indicate that UK SLT services need to increase caregiver participation in sessions, for example, by using coaching to help parents to better support their child’s health needs.
Graph 3 and 4 compares caregiver/clinician involvement in sessions from ‘MRMHT Tarrant County’ in Texas with ‘Family, Infant, Pre-school Program’ (FIPP) in North Carolina. Some early studies suggest a difference between expected and actual practices in Part C service delivery. For example home visits tended to be predominantly child-focused rather than supporting interaction between parents and child (Wilcox, Guimond & Kim, 2010; Hebbler Spiker, Morrison & Mallik, 2008; Campbell & Sawyer, 2007; Peterson et al., 2007).

Graph 3 Comparing level of caregiver involvement across two family-centred programs.
Graph 4 Comparing level of clinician involvement across two family-centred programs.

The team at MRMH Tarrant County, Texas at the time of the researchers visit had just transitioned and had been practicing the model for approximately 12 months, whereas the team at FIPP had been practicing for over 15 years and had reached ‘fidelity’. Fidelity is the extent to which practitioners are implementing an evidence-based program or practice as intended, as defined by the Early Childhood Technical Assistance Center (Smith et al., 2015). The clinicians in Texas typically had been working in clinic settings prior to their role at MRMH Tarrant County. The trends from the caregiver survey results indicate that caregivers perceived themselves as less involved and clinicians taking a lead in home visits (see graph 3 and 4). Campbell and Sawyer (2007) found 70% of observed sessions were traditional therapy within a home environment. By contrast, FIPP caregiver results indicate that as the trend increases for caregiver involvement the trend decreases for clinician involvement. 83% parents reported they are the main person involved ‘all the time’ and 50% of parents reported that clinicians are ‘rarely’ the main person involved in the session. The results, from
FIPP, support the researchers home visit observations ie. That the caregivers mostly interacted with the child directly and the clinician’s most frequent role was as facilitator/coach. The difference in results between FIPP, which has reached fidelity and MRMH Tarrant County, who are transitioning to the new model, is supported by findings from a survey of 3,300 American parents whose children received family-centred early intervention (Bailey, Hebbeler, Scarborough, Spiker & Mallik, 2004). The results suggest that a gap between theory and practice of family centeredness usually arose from a lack of involvement of caregivers which differentiates it from a therapist-centred model (McKean, Philips & Thompson, 2012). Contrasting the two services demonstrates the transition which occurs from therapist-led intervention to family-centred approaches in natural settings. The results highlight a shift that occurs within clinicians when carrying out interventions in the natural setting from viewing the caregiver as a peripheral participant in child-focused interventions to the caregiver being a central participant in the family-centred intervention (Crais, Roy, Free, 2006; Dunst, 2002). Therefore, UK clinicians would take their evidence based interventions and use coaching to help the parents carry out the interventions when the clinician is not present. The results also demonstrate the importance of training tools, such as reflective logs, joint visits, supervision and continuous professional support at team meetings and support groups in equipping staff to coach parents effectively within the child’s natural setting.

4.3.2 Transfer of skills

SLT’s in the UK typically design activities in sessions to provide specific learning opportunities with special materials and toys selected to engage the child in the activity (Campbell & Sawyer, 2007). Clinicians using a family-centred approach use materials and toys readily available to families to engage children in naturally occurring routines
but also may use specialist equipment such as PECS books, AAC devices and adaptations. Caregivers in the USA and UK were asked the following question to investigate how easy caregivers felt it was to transfer skills from sessions to daily routines:

- How easy is it for you to practise what happens during your therapy sessions at home?

**Bar chart 1** The ease caregivers reported being able to transfer skills from session to daily life.

Bar chart 1 indicates that both the UK caregivers and caregivers receiving the family-centred approach in the USA surveyed, reported similar ease of practicing activities away from the session. Families attending two USA private clinics in Texas where caregivers were not typically present, reported it was harder to transfer skills from clinic to home. The caregivers’ responses on the types of strategies and activities they used to support their child was gathered from the following statement;
I currently support my child’s speech and language using the following strategies/activities: (Please list below).

Caregivers attending two private clinics in Texas tended to ask the clinician for homework activities to carry out at home which typically focused on remediating a deficit. See examples below;

“Following through activities- articulation, drills, play based language work (rhyming words and language stimulation activities) games- matching cards with associations of sessions, showing ten signs of buildings”

“Emphasis on vowels, lip positioning, syllables. Board games, practicing word articulations. Verbal prompting using visual cues when needed.”

“Read daily, practice words by SLT, catch mispronounced words in conversation and correct them”

“Asking for homework (ie. what done in session to practice) and modelling language on iPad.”

Caregiver responses from family-centred approaches reflected whether the clinician was transitioning towards coaching or had reached fidelity. The researcher observed that caregivers receiving care from clinicians who were transitioning towards fidelity, who tended to carry out a traditional clinic sessions within the home setting reported a mix of deficit-focused (in blue) and routine-based activities (in orange). See examples below;

“Reading, playing, flash cards, talking, lots of praise and love.”
“Talking through actions (Example: ‘ready-set-go’ or saying ‘front’ and ‘back’ while on a swing.) Repeat what child says with response to statement or question. Giving description and options of objects”

“Books, outside playtime, using one word descriptions, puzzles, eating times and farm house activities.”

“Have him try to identify items or pictures. Repeat sounds or words. Encourage singing songs. Reading books to him.”

“We talk to him whenever we're doing an activity (whether it is grocery shopping or playing with toys) so he can hear a variety of words. We have "conversations" with him by imitating the sounds he is making.”

In contrast caregivers receiving intervention from a clinician who had reached fidelity, consistently reported strategies used within everyday routines. See examples below;

“Talking and interacting with baby while feeding and other activities”

“Talking to her, saying what she says, looking at her face, telling her what stuff is”

“Eye contact, using fewer words so he understands me, facial expression, signs and getting on his level”

Themes from the UK responses suggest that caregivers replicate at home specific activities suggested by the SLT during the session, such as messy play and craft. See examples below;

“I repeat the activities and strategies we been doing the session. Naming animals, objects etc. activities cutting, sticking etc. reading similar books.”
“Do the activity sheets as homework. Repeat words and actions as we come across them. Turn taking, volcano activity, emotions, surprise box, singing, drawing, picture cards”

“At present we are working on 'again' and 'help' using props eg. bubbles, balloons etc, working really well”

“Messy play, ‘what's in the bag’, nursery rhymes, playing, reading books, other activities”

“Asking the question, talking to my child for 5 minutes everyday, using pictures, use craft, face to face to talk”

“Showing pictures given by therapist, first/next, picture posting, turn taking, choosing, waiting games, listening and waiting games.”

Parents attending Parent-Child Interaction therapy reported the strategies they were using but did not identify routines in which they used them. See below;

“Following her lead, commenting on what she's doing, using simple words/short sentences, praising her, giving her time to speak.”

“Not to ask a lot of questions, give a child take a lead, praise the child.”

In summary, the results indicate that the USA private clinics surveyed provide activity ideas to remediate deficits and the family-centred approach uses PCI type strategies within routines to equip families to support the child’s communication needs. UK clinics involved in the survey typically suggest specific activities which require particular resources but also equip caregivers with PCI type strategies within the clinic
session. Therefore, a natural step for UK SLT clinics would be to equip caregivers to use PCI type strategies within the natural setting and family routines.

4.3.3 Multiple appointments and the impact on family life

Multiple appointments have been found to increase pressures on families and increase non-attendance as families start to prioritise appointments over other appointments (Touch & Berg, 2016). Caregivers in the UK and USA were asked the following questions:

- During an average month how many extra appointments does your child attend? (ie. at hospital/ physiotherapy/ occupational therapy etc.)
- How often does time taken to attend extra appointments (ie. Physiotherapy, occupational therapy, hospital appointments) impact on family life?

Bar chart 2 The impact of multiple appointments on family life in the USA and UK.
86% of caregivers from the total of responses, from both the UK and USA, reported 0 additional appointments ‘never’ impacted family life. Caregivers attending five or more additional appointments each month reported the appointments impacted family life ‘most of the time’ or ‘all of the time’.

Bar chart 3 Comparing number of additional appointments across the three settings.

Bar chart 3 indicates that from the survey responses, children attending USA private clinics and UK NHS Clinics typically attend more appointments in addition to their Speech and Language Therapy appointments, than families accessing the USA family-centred approach. The results reflect the service designs observed by the researcher in which, the USA private and UK NHS clinics observed were designed so that children attend profession specific sessions. The family-centred approach reduces additional appointments by assigning a key clinician to the family and joint working practices are more routinely used.
The results from bar chart 2 and 3 indicate that a family-centred approach can reduce additional appointments for families, reduce the impact on families and may therefore decrease DNA rates. The current findings concur with the survey results from a study by Touch and Berg (2016).

4.3.4 Structure of appointments

Caregivers were asked the following questions to investigate the following themes; scheduling, frequency and length of appointments, to investigate caregiver satisfaction levels in relation to the structure of appointments:

- How often are you asked by your therapist when it would be helpful for therapy sessions to be scheduled?

- How satisfied are you with how frequently your therapy sessions are?

- How satisfied are you with the length of therapy sessions?
Scheduling of sessions

80% of caregivers receiving a family-centred model of care reported they were asked ‘all the time’ when the next session should be scheduled. This percentage rose to from 66% for programs which had not yet reached fidelity to 89% in programs that had reached fidelity. The results reflect the flexible approach to scheduling, known as ‘FAB’ scheduling; flexible, activity-based, bursts of support. FAB scheduling is where the PSP at the end of each session discusses with the caregiver when to book the next session based on the family routine and to observe the agreed activity (Shelden & Rush, 2013).

Note: Due to a technical error on the online form, data for MRMH Tarrant County Fort Worth, Texas was not collected and so the data were removed for this question.
Responses from the UK NHS clinics surveyed, revealed an equal percentage of 19.51% across a range of responses for; ‘never’, ‘some of the time’ and ‘most of the time’, which may reflect the varying level of consultation that caregivers receive to be informed of the next block of appointments. For example, in the clinics surveyed, caregivers received an appointment letter or phone call or discussion at the end of a session. In summary, parents were more satisfied with FAB scheduling and least satisfied with the UK’s method of scheduling appointments.

**Frequency of sessions**

Bar chart 5 Caregiver satisfaction levels about the frequency of sessions.

UK NHS clinics surveyed typically provide therapy once a week for six weeks blocks before placing the child back on the waiting list for therapy. 39% of caregivers were ‘mostly’ and 49% ‘very’ satisfied with the frequency of sessions. In contrast, 80% of caregivers receiving family-centred care were ‘very’ satisfied with the frequency of the session. The family-centred approach typically provides a ‘burst’ of therapy once a
week for a six week block which is typically followed by less regular visits which are tailored to daily routine and the child’s needs.

In summary, families receiving flexible care, which may involve less frequent visits than the UK model surveyed, reported greater satisfaction than caregivers assigned a block of sessions in the UK.

**Length of session**

![Bar chart 6 Caregiver satisfaction levels around the length of individual sessions.](chart.png)

75% of caregivers surveyed, attending two private clinics in Texas, reported they were ‘very’ satisfied with the duration of the session and 25% ‘mostly’ satisfied. At the two private clinics, therapy sessions were allocated by insurers. The clinic and family can then decide the length of sessions, such as 6 x 1 hour sessions or 12 x 30 minute sessions. In the family-centred model, sessions typically last one hour. Family-centred approaches found, 75% of caregivers reported they were ‘very’ satisfied and 22% ‘mostly’ satisfied with the length of sessions. Results also indicated that family-centred programs which carried out note taking at the end of sessions result in lower satisfaction levels than when notes were written away from the visit. Sessions in the
three UK NHS clinics investigated lasted around 30-45 minutes for individual sessions and 60 minutes for group session. 63% of caregivers surveyed at the three UK NHS clinics reported they are ‘very’ satisfied and ‘22% ‘mostly’ satisfied with the length of the sessions. In summary, slightly higher satisfaction was reported when sessions were around one hour and when clinicians wrote notes outside of the session.

In brief, caregiver satisfaction increased when scheduling was flexible, when sessions were one hour and sessions were tailored to the child’s needs rather than prescribed block of sessions by the local authority or insurers.

4.3.5 Role of the Primary Service Provider (PSP)

The following questions were asked to compare parent satisfaction about the expertise and skills of Primary Service Providers (PSP) compared with domain specific therapists:

- How often do you feel the therapy sessions focus on what you think is most important for your child’s learning and development?

- How satisfied are you that your therapist has sufficient expertise and skill to manage your child’s difficulties?
Caregiver satisfaction levels with clinician's expertise and skills

Bar chart 7 Caregiver satisfaction levels with the clinician’s level of expertise and skill.

Sessions that focus on the child's learning development

Bar chart 8 Caregiver satisfaction levels on how often the sessions focused on what caregivers felt was important for their child’s learning and development.

Caregivers in all three settings felt the sessions focused ‘all the time’ on what they felt was important for their child’s learning and development, with a 10% increase in
caregiver satisfaction in family-centred programs compared to the other two approaches. The greater satisfaction levels in family-centred programs may reflect the greater influence caregivers have in the decisions made about sessions and IFSP outcomes. The caregivers’ satisfaction of the clinician’s level of skill was also measured. The results indicated that 89% of caregivers surveyed at the private clinics in the USA and 85% of caregivers surveyed at family-centred approaches reported they were ‘very’ satisfied with the therapist’s skill and expertise. However, of the UK NHS clinics surveyed, 66% of caregivers reported they were ‘very’ satisfied and 25% of caregivers reported they are ‘mostly’ satisfied with the clinicians’ skill.

In summary, caregivers reported across all three service delivery models that sessions focused on what caregivers thought was most important for their child’s learning and development. Caregivers were generally ‘very’ satisfied with the clinicians’ expertise and skill, however the UK satisfaction levels were lower than the two other USA settings.

4.3.6 Overall comments and recommending the service

Caregivers were asked for any suggestions or comments on the service they receive:

- How likely would you recommend our service to a friend who has a child with similar needs?

- Have you any suggestions for how delivery of the service can be improved?

Caregiver responses, collected from the two private clinics in the USA, reported they were satisfied with the overall service for example, 86% of caregivers reported they would ‘very’ much recommend a friend. Caregivers reported positive feedback such as, “Nice therapy place and more friendly with kids”. However caregivers were less
satisfied that insurance firms allocated the number of sessions rather than knowledgeable health professionals. For example, ‘Less focus on what insurance wants and more focus on what is good for patient and family. Not our experience here but is an overall issue with therapy (services in USA)’ and ‘Make it free’.

Caregivers receiving care from the family-centred model were satisfied with the model especially as it tailored intervention to the child and family’s needs. 82% of caregivers surveyed in the USA receiving family-centred care reported they would ‘very’ much recommend a friend. Overall caregivers did not have any further recommendations, “I think it works well the way it is. The flexibility to be in a home environment or community can conform to each family’s needs.” and “No, we've had nothing but a great experience and all the tools and feedback are very helpful” and “I've seen a tremendous improvement in my child's speech and social interaction since he started with ECI.” However, caregivers transitioning from the previous model of attending several appointments reported they would prefer to have more joint visits, for example one parents suggested, “If children qualify for more than one service then the separate sessions (we qualify for PT and speech but no extra time or therapist was added)”. Two caregivers who have received sessions from several sources reported they felt the model did not provide enough care for their child. The model they were receiving was just transitioning towards fidelity and not employing coaching fully. For example, a caregiver who receives input from several professionals as well as the PSP model reported, ‘If I didn't have the support of specialist therapy centre four days a week with all the other specialities, then I would like one of each profession in the home.’ However, caregivers with prior experience of receiving sessions at private clinics reported they were pleased there is “Less paper work (to do with insurance/billing)”. 
Caregivers receiving care from the three UK NHS clinics surveyed suggested increasing the frequency of sessions, having joint sessions between professionals and equipping caregivers more with strategies to support their child at home. 68% of caregivers attending one of the three UK NHS clinics reported they would ‘very’ much recommend a friend. Overall the caregivers were pleased with the service they received, ‘All the staff are very good with children and all very professional’. However, the most reoccurring theme was a suggestion to increase the number of sessions and reduce waiting times between blocks, for example, ‘Maybe to have twice a week therapy session rather than one week to improve therapy but I’m happy with the session....” and “Frequency of blocks. The gaps are too big! The time at this age of child's development is essential.” and “I strongly feel that therapy session (SLT) for children with autism should be weekly or twice weekly and preferably continuous for the child to benefit....” Caregivers reported that they valued being involved in supporting their child in sessions, “The therapist usually discusses with me to come up with milestones we want to achieve. The sessions are now moulded to achieve this. This is very effective and should in my opinion never be changed.” and “...(I am) equipped with strategies to do at home and (staff) write thorough reports on his improvement and future goals.” Caregivers reported that they would like to, “learn more strategies on how to support the child.” In addition, caregivers asked for more joint working between SLT’s and other professionals, for example, “...Just more sessions. Also if the nursery staff could have been given specific training to my child’s needs. Joint OT and speech therapy sessions, my child has many sensory needs...”. 

The results from the surveys indicate that caregivers attending the UK NHS clinics were less satisfied about length and frequency of sessions. UK caregivers surveyed reported they would like to be equipped to support their child and have joint sessions
between professionals. Caregivers surveyed who access the family-centred approach in the USA overall scored higher satisfaction levels than responses received from the UK caregivers as their appointments are scheduled flexibly, last one hour, they receive joint visits between professionals and children receive a burst of sessions and then occasional appointments depending on child’s need and family routine. Therefore the needs of UK caregivers, based on the comments, could be met by the family-centred approach. The researcher recognises that the results are based on a small sample size and may not be representative of every caregiver or professional’s experience of services in the USA or UK.
5 Recommendations

The following seven recommendations are based on the literature, case studies and caregiver survey results to better support 0-5 year olds health needs while meeting NHS efficiency saving targets. The researcher also intends to gain views from the NHS multidisciplinary team on the application of a family-centred approach to NHS Early Years services.

5.1.1 Caregivers as equal partners with healthcare professionals in discussions and decisions about their child’s health and care.

Initially clinicians within the NHS would require in-house training on ‘coaching’ to increase participation of caregivers in intervention. Following initial training, experienced clinicians in coaching would supervise clinicians through observations at home visits, reflective learning logs and supervision to support clinicians to effectively support caregivers by using coaching. Benefits would include; equipping parents to become lifelong advocates of their child’s health needs, increased parent participation and therefore decreased non-attendance, increased parent satisfaction, improved child health outcomes. Success would be measured using the ‘Fidelity in Practice for Early Intervention’ tool developed by a team of researchers and practitioners at FIPP to measure fidelity of clinicians. Success would also be measured by continually monitoring the caregivers’ satisfaction levels and collecting case examples.

5.1.2 Functional intervention outcomes that are meaningful for families and promote the child’s participation in daily routines.

NHS Trusts to provide in-house training on the family-centred model, using the three components; natural learning environments, coaching and primary service provider approach to teaming. Benefits would include; goals that are meaningful to families, increased participation of families, functional outcomes for children, joint working among professionals to better meet outcomes for children. Success would be measured
by auditing functional goals, experiential learning by shadowing a clinician experienced in the approach, debriefing home visits between peers, peer supervision and reflective logs.

5.1.3 Reduce costs to NHS services resulting from non-attendance by increasing caregiver participation in interventions.

Deliver training to NHS staff on coaching practices and the role of a primary service provider. Benefits include: increased parent participation, improved child outcomes, decreased non-attendance rates. Success would be measured by; supporting clinicians to reach fidelity, monitoring non-attendance rates, caregiver survey’s used to monitor satisfaction levels of perceived participation during visits.

5.1.4 Structure teams to comprise of multiple disciplines of health professionals rather than profession specific teams.

A pilot study to demonstrate application of the model in the UK using one team made up of multiple professionals and then a roll out across an NHS Trust. Benefits would include: increased joint working, reduced number of appointments required per child, increased awareness of peer professions and their practices. Success would be measured by outcome measures such as, the child meeting their functional goals, increased number of joint appointments, decreased number of appointments required per child, increased awareness amongst professionals of other disciplines.

5.1.5 Increase efficiency of team meetings.

Staff to use the team meeting structure outlined in the report, team meeting rules agreed on and skilled facilitators trained to lead meetings. Benefits include: meetings kept to 90 minutes, caseloads are summarised, team aware and involved with all children on caseload, cross-professional input and learning. Success will be measured by the team meetings using the principles outlined by Shelden & Rush (2013).
5.1.6 **Eradicate costs of renting and maintaining clinic rooms and equipment by implementing therapy in the child’s natural setting.**

NHS trusts to move intervention into the child’s natural setting, such as homes and nursery. To achieve the recommendation, the NHS would need to cease renting clinic rooms, cease buying resources/toys, continue to rent office space and a room for team meetings and supervision. Teams would need to be located within easy access of residential areas in their local area. Practitioners would use FAB scheduling to reduce travel time between appointments and travel costs. Success would be measured by reduced spending as a result of renting and maintaining estates, all appointments being carried out in nurseries or home visits, all clinicians using FAB scheduling.

5.1.7 **Reduce waiting times by prioritising children by level of need and using flexible scheduling to meet the needs of all children and families.**

Staff to be trained to use the FAB scheduling approach and clinicians assigned caseloads based on the Primary Service Provider selection process. Benefits include; reduced waiting times, increased caregiver satisfaction, more efficiently managing time and the child’s needs. Success will be measured by monitoring waiting times, clinicians prioritising children by need and clinicians to confidently use FAB scheduling.
6 Conclusion

The present study has met the aims of the project by describing the family-centred approach and considering applications to our current UK service delivery models based on; direct observations, case studies, caregiver surveys and discussions gathered both in the UK and USA by the researcher. The case studies, survey results and subsequent analysis have revealed two key outcomes. Firstly, that UK Early Years services could be more cohesive in their approach to teaming by using the Primary Service Provider approach which fosters joint working among professionals. Secondly, that UK Early Years services could create therapy services for 0-5 year olds which are part of family routines, more functional and equip parents to become lifelong advocates for their child’s health needs.

6.1.1 Sharing findings

Following the completion of the report the researcher will be sharing the findings both nationally and locally. At a national level, the researcher will be presenting at the Royal College of Speech and Language Therapists (RCSLT) conference, Glasgow, 2017. At a local level, the researcher will present the findings to colleagues at an annual whole Speech and Language Therapy team meeting. The researcher also intends to maintain the contacts made in the USA with the view to implement a family-centred approach of service delivery to improve the health outcomes of children age 0-5 years old in the UK.
7 References


Carroll, C. (2010). ‘‘It’s not every day that parents get a chance to talk like this’’: Exploring parents’ perceptions and expectations of speech-language pathology services for


8 Appendices

8.1 Programs Visited in the USA

Below are links to websites providing more information about the organisations visited by the researcher in Texas, Kansas and North Carolina:

Private Clinics, Austin, Texas

Little Tesoros Therapy Services [www.littetesoros.com/about-us/](http://www.littetesoros.com/about-us/)


Family Centred Programs

MHMR of Tarrant County, Texas [www.mhmrtarrant.org/Services/Early-Childhood-Services](http://www.mhmrtarrant.org/Services/Early-Childhood-Services)

Family, Infant and Preschool Program, North Carolina [www.fipp.org](http://www.fipp.org)

Johnson County Infant-Toddler Services, Kansas [www.itsjc.org/about/](http://www.itsjc.org/about/)

Pottawatomie/Wabaunsee Infant-Toddler Services, Kansas [www.tiny-k.org/](http://www.tiny-k.org/)

Wyandotte County Infant-Toddler Services, Kansas [www.tiny-k.org/](http://www.tiny-k.org/)

Shawnee County Toddler Services, TARC tiny-k, Kansas [www.tarcinc.org/project/tarc-tiny-k-program/](http://www.tarcinc.org/project/tarc-tiny-k-program/)
8.2 FIPP Casetoools: Worksheet for selecting the *most likely* Primary Service Provider

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Parent/Family Factors</th>
<th>Child Factors</th>
<th>Environmental Factors</th>
<th>Practitioner Factors</th>
<th>Most Likely PSP</th>
<th>SSP Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List Priorities with contexts</td>
<td>List Diagnosis/Condition/Needs (Long term view)</td>
<td>Natural Learning Environments (circle)</td>
<td>Knowledge/Expertise (personal/professional)</td>
<td>Optional Selected</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parent/physician Request</td>
<td>List Interests/Activity Settings</td>
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<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Parent/Family Factors</th>
<th>Child Factors</th>
<th>Environmental Factors</th>
<th>Practitioner Factors</th>
<th>Most Likely PSP</th>
<th>SSP Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Dynamics</td>
<td>Individual parent/caregiver characteristics</td>
<td>Safety</td>
<td>Primary service area in geographic region</td>
<td></td>
<td>Role Overlap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Language/culture</td>
<td>Distance from program office</td>
<td>Billability</td>
<td></td>
<td>Role Overlap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knowledge/expertise</td>
<td></td>
<td>Prior relationship</td>
<td></td>
<td>Role Overlap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis/condition</td>
<td></td>
<td>Rapport</td>
<td></td>
<td>Role Overlap</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Parent/Family Factors</th>
<th>Child Factors</th>
<th>Environmental Factors</th>
<th>Practitioner Factors</th>
<th>Most Likely PSP</th>
<th>SSP Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Availability</td>
<td></td>
<td></td>
<td>Availability</td>
<td></td>
<td>Role Overlap</td>
</tr>
</tbody>
</table>

Notes:

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### 8.3 FIPP Case tools: Joint Planning Tool

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**JOINT VISIT PLANNING TOOL**

PSP: ________________ Family: ________________ Child: ________________  
SSP: ________________ Date of Joint Visit: ________________ Time: ________________

<table>
<thead>
<tr>
<th>Request for Role Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question or issue requiring support of another team member (joint visitor)</td>
</tr>
</tbody>
</table>

What you (Primary Service Provider - PSP) and/or the parent need from the joint visit: (Secondary Service Provider - SSP)

<table>
<thead>
<tr>
<th>Background Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your (PSP) and/or the parent's current knowledge and actions taken regarding the question/issue</td>
</tr>
<tr>
<td>Current child interests and activity settings that serve as the context for intervention</td>
</tr>
<tr>
<td>Current parent priorities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
</tr>
</thead>
</table>
| a. Conversation that will take place with the family about the joint visit  
(Questions to consider: When will you have the conversation? What questions need to be answered by the SSP? What does the SSP need to observe? What will be the context for the visit? What does the SSP need to know? Who should take the lead - PSP or SSP?) |
| b. Context for the visit and rationale |
| c. Person taking the lead in the visit (SSP or PSP) and rationale |
| d. Role of the person not taking the lead and the family during the visit |
| e. What is going to happen during the visit |
| f. Date/time for debrief of the joint visit with the SSP and family |

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8.4 Caregiver Survey (USA)

Early Intervention Caregiver Survey

I am a Speech and Language Pathologist from London, England. I am conducting research funded by the Winston Churchill Memorial Trust on American early intervention services so we can share best practices with our services in the UK. All answers will remain confidential and anonymous. Please answer all questions and write comments/suggestions in the spaces provided. Thank you for your help.

Today’s date:       Age of child:
                     Gender of child:

1. How often are you the main person involved in the activity with your child during your early intervention visits rather than your provider?
   Never  Rarely  Some of the time  Most of the time  All of the time

2. How often is the provider the main person involved in the activity with your child during your early intervention visits?
   Never  Rarely  Some of the time  Most of the time  All of the time

3. How often are you asked by your provider when it would be helpful for the next early intervention visit to be scheduled?
   Never  Rarely  Some of the time  Most of the time  All of the time

4. How easy is it for you to practice what happens during your early intervention visits with your child as part of your daily activities between visits?
   Not at all  Not very  Somewhat  Mostly  Very

5. I currently support my child’s speech and language using the following strategies/activities: (Please list below)

6. How often do you feel the early intervention visits focus on what you think is most important for your child’s learning and development?

7. How satisfied are you with how frequently your provider comes to visit you?
   Not at all  Not very  Somewhat  Mostly  Very

8. How satisfied are you with the length of your visits?
   Not at all  Not very  Somewhat  Mostly  Very

9. How satisfied are you that your provider has sufficient expertise and skill to manage your child’s difficulties?
   Not at all  Not very  Somewhat  Mostly  Very

10. During an average month, how many extra appointments does your child attend?
    (i.e., hospital, Physiotherapy, Occupational Therapy etc.)
    0  1-4  5-8  9-12  Other appointments

11. How does time taken to attend the extra appointments (i.e., Physiotherapy, Occupational Therapy, Hospital Appointments) impact on family life?
    Never  Rarely  Some of the time  Most of the time  All of the time

12. How likely would you recommend our service to a friend who has a child with similar needs?
    Not at all  Not very  Somewhat  Mostly  Very

13. Have you any suggestions for how the delivery of the service can be improved?
8.5 Caregiver Survey (UK)

One of our Speech and Language Therapists (SLT) has gained funding from the Winston Churchill Memorial Trust to compare SLT services in the USA with our SLT services here. We would be grateful if you would complete the survey below to tell us about your experiences of Speech and Language Therapy. Your answers will help us find out what we are doing well and how we can improve. All responses will remain anonymous and confidential. Please answer all questions and write comments/ suggestions in the spaces provided. Thank you for your help.

Today’s date: 
Age of child: 
Type of therapy: 
Gender of child: 

14. How often are you the main person involved in the activities during the therapy sessions with your child?
Never 
Rarely 
Some of the time 
Most of the time 
All of the time

15. How often is the therapist the main person involved in the activities during the therapy sessions with your child?
Never 
Rarely 
Some of the time 
Most of the time 
All of the time

16. How often are you asked by your therapist when it would be helpful for therapy sessions to be scheduled?
Never 
Rarely 
Some of the time 
Most of the time 
All of the time

17. How easy is it for you to predict what happens during your therapy sessions at home?
Not at all 
Not very 
Somewhat 
Mostly 
Very

18. I currently support my child’s speech and language using the following strategies/activities. (Please list below)

19. How often do you feel the therapy sessions focus on what you think is most important for your child’s learning and development?
Never 
Rarely 
Some of the time 
Most of the time 
All of the time

20. How satisfied are you with how frequently your therapy sessions are?
Not at all 
Not very 
Somewhat 
Mostly 
Very

21. How satisfied are you with the length of your therapy sessions?
Not at all 
Not very 
Somewhat 
Mostly 
Very

22. How satisfied are you that your therapist has sufficient expertise and skill to manage your child’s difficulties?
Not at all 
Not very 
Somewhat 
Mostly 
Very

23. During an average month how many extra appointments does your child attend? (i.e. at hospital, physiotherapy/ occupational therapy etc.)
0 
1-4 
5-8 
9-12 
Other appointments
If other, please specify:

24. How often does time taken to attend the extra appointments (i.e. Physiotherapy, occupational therapy, hospital appointments) impact on family life?
Never 
Rarely 
Some of the time 
Most of the time 
All of the time

25. How likely would you recommend our service to a friend who has a child with similar needs?
Not at all 
Not very 
Somewhat 
Mostly 
Very

26. Have you any suggestions for how the delivery of the service can be improved?

