

Interdisciplinary Team Assessment: CRC Style

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Introduction to the Central Remedial Clinic

The Central Remedial Clinic (CRC) is a national non-residential centre that provides multidisciplinary services for children and adults with physical and multiple disabilities. Within the group of clients attending the clinic, there is a broad spectrum of levels of need and severity and this can determine the type of intervention they receive from the service. New clients to the Clinic are discussed at a referrals meeting with the Medical Director and the Managers of therapy and social work departments. Traditionally each department sees children individually for assessment. In some situations, if the referral information indicates the need for it, individual therapists working with a particular child arrange combining their assessments. In addition, some clients are scheduled for specific team intervention, for example, the Muscular Dystrophy Team and the Feeding Team.

Introduction to Team Assessment Clinic

In 2002, a new team approach to assessment, the Team Assessment Clinic, was introduced. The Team Assessment Clinic (TAC) is specifically aimed at meeting the needs of infants under three years of age presenting with severe, multiple and complex needs, from the Eastern Regional Health Authority (ERHA). Currently fourteen per cent of total referrals from the ERHA are for the TAC. These children are identified as requiring intervention from all therapy departments, social work and Paediatrician. As part of the work of a subcommittee examining the area of consulting with clients about their programmes, a focus group of parents held in 2003 in the CRC identified a link between the level of disability and level of need for consultation. TAC is a response to the need for a structured approach to these children's needs, the need to work as an interdisciplinary team and to facilitate greater involvement of parents in the process.

The ideas within 'Interdisciplinary Team Model' and 'Person-Centred Planning' (PCP) have become guiding principles in our development of TAC. The assessment is conducted by a team of professionals who collaborate with each other and with the child's parents, in order to provide a holistic view of the child and to establish a coordinated plan of intervention. The system allows for flexibility so that children who do not require the whole team input can continue to attend individual departments. Parents are recognized as valuable members of this team who are encouraged to be actively involved in the assessment process, in decisions made about their child and in therapy programmes. In order to provide a broader perspective of the process of the TAC, the 'Interdisciplinary Team Model' and principles of 'PCP' will be addressed.

Interdisciplinary Team Model

According to Case-Smith (2001):

“in the interdisciplinary model of interaction, a team of professionals from several disciplines involved with the child collaborates with the family to develop and implement an intervention program. With this approach the child and family can receive coordinated services and are able to benefit from the expertise of professionals from several disciplines who are directly involved. To ensure the success of this approach, the team members must respect one another’s roles, develop efficient formal and informal communication patterns, and be flexible in response to family preferences. This requires a willingness to share expertise and knowledge and to assume accountability for intervention procedures.”

In the USA, services for individuals with disabilities are governed by Federal Law, and regulations enacted during the 1970s specify that services for individuals with disabilities should be developed by an interdisciplinary team and provided through individualized goal-based plans for care (Jacobson, 1987). Standards for accreditation of facilities in the USA requires an interdisciplinary team and an individual goal plan.

The Education for Persons with Disabilities Bill 2003, due for enactment in Ireland in 2004, states that education services should be based on an individualized assessment of need and that parental involvement, and where possible involvement of the person with disabilities, should be a central element of the process. These members of the team have a power of veto on any provision within the Individual Education Plan (Education for Persons with Disabilities Bill, 2003).

A survey by a UK disability organisation found that many parents of a child with complex needs had feelings of being excluded from plans for their child and that this had a negative impact on them. For example, parents felt that professionals spoke to each other about their child but had left them out of the conversation. In contrast, the same survey found that parents who were involved in decision making appreciated having their input encouraged and that this contributed positively to their well being (Limbrick-Spencer, 2000).

Person-Centred Planning (PCP)

Higgs (2003) states that *“...person centred planning is a process of life planning for individuals, based around the principles of inclusion and the social model of disability.”* PCP began about twenty years ago in North America, with John O’Brien being at the forefront of this revolution. The core of the PCP approach involves clients being central to planning their own futures, with therapists taking a facilitative role.

When PCP is carried out in its entirety, the client, and in some cases the family, take control of the process. They have an opportunity to voice their hopes, dreams, fears and vision of their own future within an informal but structured process, concluding with clear positive statements about the client's future. Responsibilities for meeting identified action plans are assigned and a date is set for review. This information is then used by the therapists to direct intervention, and help the client develop in the direction they have chosen.

Person-centred planning has been adopted as policy in the North American education system. In Ireland, the National Disability Authority (NDA) and the Department of Health and Children (DHC) are targeting the development of disability services, and have identified five major areas of service delivery:

- 1 Person-centred services;
- 2 Leadership and Governance;
- 3 Management staffing and training;
- 4 Information and communication services;
- 5 A safe environment.

In relation to person-centred services, the *National Standards for Disability Services* state that:

"Each service user receives person centred services and supports designed to meet his or her goals, needs and stated preferences."

Such a service will provide information about rights and entitlements, regular assessment of need, opportunities for social inclusion, advocacy, and develop and maintain independence.

Within the TAC process, we have endeavoured to include some of the PCP principles. Parents are encouraged to be active participants in both the actual assessment with their child, providing feedback regarding the child's abilities and difficulties in all areas of development. Parents are also active in guiding the process by providing the other team members with their own priorities and concerns. Part of the social worker's role is to encourage parents' active participation in the assessment, and when needed, to clarify information for the parent.

O'Brien (1998) identifies two key concepts in PCP: active listening and the use of insight questions. Therapists employ active listening, and as such, are focused on what is being said verbally (e.g., paralinguistic by voice, volume, pitch etc.) and nonverbally (e.g., facial

expression, gesture and posture etc.) (Burnard, 1995). The use of insight questions, for example, *“how do you feel about your child’s progress?”*, allows for greater understanding of a situation. According to O’Brien (1998), insight questions can be difficult to ask and difficult for the parent to answer, but through this process, team members, including the parents/caregivers, can develop a deeper connection and have greater awareness and understanding for identifying goals and devising action plans.

TAC is about bringing people together, each bringing their own knowledge, experiences and feelings. Professionals actively listen to parents/caregiver’s concerns, hopes and needs, while providing choice, whether it be the primary focus of therapy, appointment times or information shared. Goals are not discipline-specific but rather holistic, with emphasis on the child’s needs. This lends itself to a plan that meets the individual needs of the child, and a plan that everyone feels committed to.

TAC Process

The Team Assessment Clinic is made up of the following: child, parent/guardian, physiotherapist, occupational therapist, speech and language therapist, social worker, paediatrician and the team appointment coordinator. The criteria used for identifying children involve specific characteristics, such as prematurity, brain haemorrhage, presence of seizures etc. If a child is identified for TAC, the referral letter is sent to the team appointment coordinator who then sends an appointment letter and a copy of a brochure to the child’s family.

Prior to attending TAC, each family will have had an appointment with their child’s paediatrician. Before their TAC appointment, the social worker, who already knows the family, meets with the parents and goes through with them who is involved in TAC, discusses their concerns and outlines what to expect on the day. It has been our experience that some parents have worries that they will be judged and one parent spoke of going *“before the panel.”* The social worker’s role is to help reassure parents and also make the other members of the team aware of parents’ anxieties.

On the Day of the Assessment

The time allotted for the assessment is from nine to twelve-thirty. Prior to the arrival of the child and family, general preparation takes place followed by discussion amongst team members. This is a valuable time for team members as any concerns that may have been previously expressed to the Social Worker can be shared. The Social Worker will try to meet parents in reception, bring them to the meeting, and introduce them to the other team members.

The assessment with the child and parents generally requires one hour, followed by a short break for the family, while team members consult with each other and discuss their thoughts and impressions. The family and team members come together again and feedback is provided. Together the parents and professional decide upon joint action plans. Referrals to other departments such as the Psychology and the Seating and Mobility departments are discussed with the family. Upon completion of the assessment of the child and consultation with the parents, a report, and a home programme if indicated, is written. Feedback is provided to the child's paediatrician and future appointments are made by the team appointment coordinator. Follow up appointments are arranged according to the child's needs. For example, one child may receive immediate regular input from the therapists, while another may only require six monthly review. Flexibility from therapists is the key to the success of this approach.

An Assessment with a Difference

As previously discussed, the TAC is based on principles of person-centred planning and the interdisciplinary team model. Parents are encouraged to be active participants in both the actual assessment with their child, and also in guiding the process by providing the other team members with their own priorities and concerns. The social worker encourages parents' participation in the meetings, and if necessary, takes on the role of asking questions to clarify matters. A common source of frustration and difficulty for parents is the need to deal with a multiplicity of professionals. A positive aspect of the TAC identified by parents at the CRC is seeing therapists together. This has meant fewer appointments, which reduces pressure and time required away from work or home.

A benefit of the overall approach adopted within the TAC process is that this approach contributes to the continuum of family support. Parents are made to feel listened to, that they have a contribution to make and are offered choices. When parents' views are valued, they feel they have more control over decisions about their child's health. TAC helps instil in parents a sense of control over the plans for their child. Sloper (1999) established that for parents of children with severe disabilities, having a sense of control is an important personal resource and that it is a helpful contributor to parental well-being.

Another effective aspect of the TAC is its basis on the interdisciplinary model of interaction. The assessment involves all therapists interacting with the child and parents/guardians at the same time, in the same room, each helping to facilitate skills being assessed. Interdisciplinary work facilitates the child being seen as a whole individual, whose needs and characteristics overlap and interface.

Case Example

A case example will be used in order to illustrate the way in which TAC has adopted the interdisciplinary team model. Cian was born at 42 weeks with no complications at birth. At four to five months of age, Cian was diagnosed as having a metabolic disorder.

From the team assessment, it was identified that Cian had significant delay in all areas of fine motor development, gross motor development, communication (in both his understanding and expression) and play skills. Feeding skills were also identified as a concern. The recommendations made were: Cian to be seen for a block of joint occupational therapy, physiotherapy and speech and language therapy and that the social worker meet with Cian's parents to discuss entitlements and supports available. At the time of the team assessment, Cian had been referred to physiotherapy and had been referred to the dietician at the CRC by the consulting paediatrician. Cian consequently was assessed at the Feeding Clinic the following month.

The interdisciplinary model recognises that each professional has their own area of expertise and the specific skills sought in a programme will be different. However, this model also recognises that each professional will respect each other's roles while also having a deep understanding of each. The goals and the plans for Cian were integrated to keep the intervention child/family centred. The focus of intervention in joint therapy sessions, with the occupational therapist, physiotherapist and speech and language therapist, was to work toward the following goals through identified strategies with Cian's parents. The first goal identified was that Cian would be ready for therapy. The strategies used to achieve this included increasing Cian's level of alertness and tone through proprioceptive activities (e.g. in supported sitting on a ball or lying prone on a ball; gentle bouncing or rocking movements). The outcome of this intervention was that Cian was alert and worked for forty minutes.

The second goal identified was that Cian would achieve lip closure and sound making. The strategies used were increasing Cian's postural tone through handling and positioning and providing a physical prompt below his chin with facial stimulation. The outcome of intervention was that Cian achieved weak lip closure and kissing in turn-taking sequence consistently by the end of the session. Goal three was that Cian would demonstrate cause and effect through the use of the following strategies: Ensuring Cian was well supported (e.g. in corner seat, with table to support arms); activation of tape recorder; positioning of switch off Cian's midline to his right; provision of multisensory feedback (e.g. touch, praise, dance and movement) and labelling of single word level. The outcome was that Cian demonstrated cause and effect consistently during sessions when supported.

The final goal identified was that Cian would eye point to a named object held at midline, would reach, grasp and then maintain his grasp for ten seconds while maintaining his head at midline. The strategies included ensuring Cian was well supported (e.g. in corner seat, with table to support arms); toys were held at Cian's midline; drawing Cian's attention to the toys by shaking it; ensuring toys could be easily grasped by Cian (e.g. size, shape). The outcome for this final goal was that, with practice, Cian was successful in achieving the goal; head control needs continued intervention.

The success of this approach was based not solely on Cian's response but also on the remarks from Cian's parents. They have commented that instead of having so many separate therapy programs to work on throughout the day, this approach has simplified everything. "*It's practical and makes sense.*"

Summary

The guiding principles of TAC as outlined in this paper are the Interdisciplinary Team Model and PCP. Parents have commented favourably on the opportunity to ask questions of all the therapists together, feeling it is of benefit "...to have all therapists to get their outlook." One mother stated that initially she was nervous and wanted to give the right answers, however, she left the assessment feeling that her opinion was valued and that she was the expert on her son. Another parent has commented that as well as the therapist asking her questions, that this was the first opportunity she had to ask questions with all the therapists together, at the same time, in the same room. Parents have indicated that the characteristics they find most helpful when dealing with staff were when professionals are approachable, open, honest when giving information and when they listen (Sloper and Turner, 1992). TAC has evolved vastly during the past two years in its interdisciplinary approach and emphasis on person-centred planning. Informal feedback from professionals, and as well as from parents, has been positive. However, it is planned to achieve objective feedback in the future. In addition, a process will be developed to further the involvement of parents in decisions made for their child. This will be a long term goal, yet one that will be essential to the future of TAC and its future success as a service of excellence for parents and their young children with severe and multiple needs.

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