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Lauren Breen
Edith Cowan University

Helen Wildy
Edith Cowan University

Sherry Siggers
Edith Cowan University

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Challenges in Implementing Wellness Approaches in Childhood Disability Services: Views
from the Field

Lauren J. Breen*

Social Justice Research Centre

Edith Cowan University

Helen Wildy

Faculty of Education

The University of Western Australia

Sherry Sagers

National Drug Research Institute

Curtin University of Technology

*Contact details for correspondence:

270 Joondalup Drive

Joondalup

Western Australia 6027

Australia

Tel: +61 8 6304 5162

Fax: +61 8 6304 5866

Email: l.breen@ecu.edu.au

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Abstract

Despite increasing demand for wellness approaches from disability advocates and consumer groups, they are not implemented routinely in childhood disability services. Interviews were conducted with 23 allied health therapists and managers working within four Australian childhood disability services. They described attempts to embed wellness approaches into their policies and practices. The participants were challenged by professional and technical issues arising from moving towards wellness approaches. The professional challenges concerned changing professional identity and working collaboratively with therapists from different disciplines. In addition, they were challenged by technical issues of balancing quality of care with economic imperatives and the speed of change expected to adopt a new model of care. The findings have implications for the quality and delivery of services and supports for children with disabilities and their families, for future research, and for the training of allied health professionals.

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Challenges in Implementing Wellness Approaches in Childhood Disability Services: Views from the Field

Childhood disability services have experienced significant and rapid change. In just a few decades, the institutionalisation of children with disabilities has been replaced with the provision of community-based services for these children and their families. Paralleling this change, the disability advocacy and consumer rights movements have gained momentum (Newman & Vidler, 2006). The social model of health and disability, which conceptualises disability as the result of social and environmental barriers that are hostile to impairment, has been developed (Oliver, 1983) and embraced widely (Barnes & Mercer, 2004). The social model of health underpins several key health policies including the United Nations' (1993) *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* and the World Health Organization's (2001) *International Classification of Functioning, Disability and Health*. Both documents promote the social participation and equality of people with disability.

Childhood disability has a wide-ranging impact on the family. The everyday experience of families living with childhood disability may be coloured by economic hardship (Brandon & Hogan, 2004), social isolation (Green, 2007), limited recreational time (Mactavish, MacKay, Iwasaki, & Betteridge, 2007), and the need to negotiate complex and under-resourced services (McDonald & Zetlin, 2004). Furthermore, the presence of childhood disability within the family tends to exacerbate other disadvantage, including economic (Park, Turnbull, & Turnbull, 2002), ethnic and cultural (Fazil, Bywaters, Ali, Wallace, & Singh, 2002), and gender disadvantage, with mothers expected to provide the bulk of the care (Leiter, 2004). Wellness approaches are thought to acknowledge these complexities and promote client wellbeing, individual choice, independence, and the right to meaningful and productive lives (Breen, Green, Roarty, & Sagers, 2008).

Changing Models of Care: Towards Wellness

The World Health Organization (1948) defined health as “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity” (p. 2). This idealistic, enduring, and holistic *wellness* approach to defining health is supported by a growing body of empirical evidence demonstrating efficacy. For instance, wellness approaches such as family-centered practice, community-based services, and self-management and empowerment programs have been shown to improve health status (Lee, Arthur, & Avis, 2006), promote well-being (Eklund, Sonn, & Dahlin-Ivanoff, 2004), reduce hospitalisation rates and duration (Perkins & Clark, 2001), and increase client satisfaction with services (G. King, Cathers, King, & Rosenbaum, 2001). Additionally, wellness approaches are cost effective (Ipsen, Ravesloot, Seekins, & Seninger, 2006; Stave, Muchmore, Gardner, 2003). Similarly, there is a growing body of evidence that medical models may limit the efficacy of allied health service delivery in childhood disability services (Betz et al., 2004; G. King et al., 2001).

In a review of the literature, the six distinguishing features of a wellness approach were identified as holistic understandings of health; the shared control between client and practitioner; the provision of individualised support, therapy and intervention; the use of multidisciplinary teams; the delivery of services from a community-based setting; and advocacy and/or the politicisation of health (Breen et al., 2008). Despite the ongoing rhetorical and policy shift towards wellness approaches to health and disability, the health and disability sectors remain highly influenced by economic and medical discourses (Bowles, 2001). Indeed, the medical model continues to dominate the training and practice of many health professionals (Goggin & Newell, 2005; Goodgold, 2005). Key components of medical and wellness approaches to health service delivery are compared in Table 1.

[Insert Table 1 about here]

Further, recent research indicates the incorporation of innovation in health care, such as a wellness approach, is dependent upon the characteristics of the innovation, the views of the professionals and clients, and the social, organisational, economic, and political contexts within which the innovation is housed (Grol & Grimshaw, 2003). The translation of wellness from theory into policy and practice requires complex changes to allied health education, research, and delivery (Breen et al., 2008) but is fundamental in addressing client and family well-being.

A recent study of the policy and procedure documents of major childhood disability services providing allied health services within Australia demonstrated the presence of wellness at the rhetorical level (Breen & Saggars, 2009). For instance, while none of the services used the term 'wellness', they did make reference to all six features of wellness approaches. One barrier to promoting wellness is that allied health practitioners and managers working in childhood health and disability services do not share definitions of wellness, which reduces their capacity to incorporate wellness into practice (Breen, Wildy, Saggars, Millsted, & Raghavendra, 2009). The ways in which wellness approaches are embedded in and enacted by services remains unclear.

This paper identifies the challenges allied health professionals face as they incorporate in their practice wellness approaches to childhood health and disability.

Methodology

The data for this paper were drawn from a larger study that emerged from a university-industry partnership involving four childhood health and disability services as research partners. The larger study examined how wellness can be embedded in the visions, policies, and practices of allied health providers working in childhood health and disability settings.

A qualitative approach was used to examine the phenomenon of a wellness approach within childhood health and disability services. Qualitative methodologies are useful in capturing the complexities of disability services because the data tend to be rich, detailed, and holistic (Ghesquière, Maes, & Vandenberghe, 2004). The approach enabled the views of the participants to be at the forefront of the research. Data were drawn from face-to-face interviews with allied health professionals.

Sample

The sample consisted of 23 allied health professionals (four each of occupational therapists, physiotherapists, speech pathologists, psychologists, and social workers, and three managers/policy makers). Their experience in working with children with disabilities ranged from 6 months to 30 years ($M = 9.41$, $SD = 9.04$). Six men and 17 women participated. The professionals were sampled from four childhood health and disability services in three Australian states – Western Australia, South Australia, and Queensland. The services provide allied health care to children either for specific or multiple impairments. Two provided services throughout the state and two were localised to specific metropolitan areas. One service is a government agency and the remaining three are not-for-profit agencies, and were the study's research partners. All professionals who were approached to participate agreed to being interviewed. Six participants were sampled from three services and five from the fourth service. An occupational therapist, physiotherapist, speech pathologist, psychologist, social worker, and a manager/policy maker were interviewed from each. Further demographic information is not provided to protect the identity of the participants.

At the time of data collection, all four services involved in our study described working within a family-centered model of care. Family-centered practice is a philosophy and an approach concerned with collaborating with each family on an individual basis to determine the services the family and the child will receive (S. King, Teplicky, King, &

Rosenbaum, 2004). One service described being on the cusp of moving to the life needs model, which involves the provision of services based on families' need and the developmental stages of each child (G. King, Tucker, Baldwin, & LaPorta, 2006).

Data Collection

Following ethics approval in March 2007, access to each of the four services was facilitated by the partner investigator(s) who identified potential participants and invited them to participate in a one-on-one interview with the first author. The interviews occurred between September and November 2007. The purpose was to determine how wellness approaches are embedded within their practice. The participants were not given a definition of wellness or a wellness approach and instead were asked early in the interview to provide their own definitions of the terms. The interview covered the following topics: their professional background and experience, duties of their job, the development and practice of wellness within their service, and additional beliefs about the factors that facilitate and impede the incorporation of wellness in their service. The questions were open-ended (see Appendix) and the respondents were asked to provide examples from their experiences in their services. The interview questions were trialled with the manager of client services at one of the services, which resulted in changes to the wording of some questions and their order. All interviews occurred in a private room at each workplace and were audio digitally-recorded. Each interview lasted between 45 and 60 minutes.

Data Analysis

Each interview was transcribed verbatim. The data analysis began as soon as possible after each interview with reading and re-reading of the interview transcripts. Interim analysis began as soon as possible to minimise inaccurate interpretations of the data and to aid further sampling and exploration of ideas in subsequent interviews. The analysis was based upon the strategy of constant comparison (Lincoln & Guba, 1985) to identify the factors that facilitate

and inhibit the implementation of wellness by the allied health professionals. The data were compared line by line, question by question, and interview by interview. The coding process involved underlining and circling aspects of the transcripts and rewriting it as an abstract concept in the margin of the transcripts and enabled the discovery and naming of categories and the detection of links between them. These codes (e.g., role adjustment, therapists' self care) were then collapsed into categories (e.g., professional identity), which were subsequently developed, refined, and integrated into themes (e.g., professional challenges to implementing wellness) according to similarities and differences in the data. The emerging thematic scheme was continually refined throughout the analysis process and write-up of the findings. The process was aided by the comparison between the data and the existing literature, enabling a data-driven approach to interpretation. Finally, quotes from the participants were chosen to illustrate the themes. An outline of the analysis process is provided in Table 2.

[Insert Table 2 about here]

The primary analysis was conducted by the first author under the supervision of the subsequent authors, one of whom also attended three interviews and read all the interview transcripts. A 30 minute presentation on the project was offered to all sites so that all interested staff members had the opportunity to hear a summary of the preliminary data and provide feedback. The data and preliminary interpretations were also circulated among the team and discussed during several team teleconferences with representations from the four services. The analysis process and interpretations were confirmed through the engagement in these processes, which served to minimise researcher bias in the extraction and development of data themes and promote rigour.

Findings and Interpretations

Our analysis of the interview data indicated that a pervading theme regarded the challenges to embedding wellness, and it is these data that form the basis of this paper. The participants spoke about the flaws they perceived of the medical approach to childhood disability service delivery and acknowledged the role of the consumer movement in precipitating the change towards embracing a wellness approach. For instance, an occupational therapist stated, “health care consumers don’t want to be babied anymore; they don’t want that medical model of being told what they need, they want to tell us”.

Despite the desire, for the most part, to move towards wellness, the participants noted that its implementation is fraught with the difficulties inherent in adopting new models of care. A key difficulty was the need to generate the necessary organisational change to support the transformation from wellness theory to wellness practice. For instance, the participants described the transition to a wellness approach as being fragmented and incoherent. One occupational therapist describing wellness within her service as “practised in bits and pieces” while a social worker stated her service practiced wellness “to a small extent”. A psychologist described, “I think the next step is how we actually roll it out and deliver it on the ground... I think you can have an ideal, but in practice it’s harder work”. The participants recognised that change, whether on an individual basis or organisation-wide, is a long-term process. For example, a psychologist asserted, “I think that if I look over five years, I’ve definitely changed how I operate but you don’t necessarily notice the small incremental things you do different[ly]”.

In moving towards implementing wellness approaches to childhood disability, the therapists described being challenged by four issues. The first two issues reflected professional concerns: (a) professional identity and (b) working collaboratively with therapists from different disciplines. The second two issues reflected technical concerns: (a)

balancing quality with economic imperatives and (b) the speed of change. Each of these is discussed below.

Professional Challenge 1: Professional Identity

The first professional challenge centered on the impact of a wellness approach on the therapists' professional identity. The participants' discussions of professional identity comprised four aspects including (a) the professionals' adjustment to their new role, (b) communicating this new role to their clients and families, (c) expanding this role to include advocacy, (d) and the therapists' self-care. Participants were challenged by the difficulty of adjusting to a model requiring more consultation with clients and families and training parents to provide components of the therapy and less hands-on, one-to-one therapy. The participants noted that some allied health professionals find it difficult to embrace the requirement to share control with their clients and families, a key component of a wellness approach. For example, some of their colleagues were described as being educationally and philosophically-bound to the medical and expert models, particularly "older people [who] have worked in that model before or [worked] in that model overseas" (speech pathologist, service 2). For some of the more experienced therapists, their attempts to adopt an alternative philosophy of service resulted in a blurring of their professional identity because they felt their 'expert' role was diminished. One senior physiotherapist (service 1) commented, "I'm a very clinical person. I'm a physio and I'll always be a physio because I like to be a physio and I like to be hands on but I understand that my role [now] is much less of that". A manager (service 2) reported:

Some staff still find it difficult to accept that 'I've undertaken all this professional training and trying to make a decision for the good of this client, and I've got a parent shaking their head and saying 'this is not the best way to

do it?’ Who are they to question my expertise and training?’ So some staff are still coming to terms with that. Some are really finding it difficult.

This loss of professional identity was reflected in the participants’ discussion of their current roles, which for some included various non-professional activities. For instance, the moves towards family-centered practice, child-centered practice, and play-based learning models (and at times a lack of administrative support) meant that some allied health professionals grappled with the application of their technical expertise in the home or community context rather than a clinical context. For example, one social worker (service 4) asked, “Why are they making play dough? The speech pathologist making play dough – yeah that makes sense (sarcastic). Cleaning up in the kindy [the service’s kindergarten] – they’re not professional tasks”. In addition, some participants thought that there was a dearth of continuing professional education and on-the-job training to facilitate them practicing their skills holistically and in non-clinical settings.

The second aspect of the challenge is communicating the role with clients and families. The challenge arose when families’ expectations of the allied health professionals differed to the services those professionals could realistically provide, with many families characterised as *expecting* a more medicalised or directed approach where the ‘expert’ will tell them what to do. For example, a psychologist (service 3) commented that many families “think you’re the professional and you just need to come and do it for them” while an occupational therapist (service 1) stated that doing so leads to “dependent relationships and therapists are overwhelmed by their client numbers and the families are stressed because they’re not getting as much therapy as they were led to believe they would”. In the attempt to work from a more consultative approach, the potential for some resistance from parents and families used to receiving a more ‘expert’ approach was also highlighted:

[For] the families [who] have been with us a long time, we really need to do a lot of work I think, and we need to be attuned to that and some of those families might not ever change [their expectations]. They might just keep going the old way until they leave [the service]. I think if we all start talking, and using the language and the terminology, the new way of managing things, the families will come around. (Senior speech pathologist, service 1)

Importantly, many participants were aware of the need to negotiate the care of the child within the circumstances of the family, echoing G. King and Meyer's (2006) assertion that the provision of coordinated care for children with disabilities and their families should be a "fundamental goal" (p. 477) of service providers. Consistent with a wellness approach, these participants thought that the provision of individualised support tailored to the needs and unique circumstances of each child and family. Indeed, many families access services for their child/children from numerous stakeholders and doing so has been described as "a bit like running a small business" (Kingdom & Mayfield, 2001, p. 38). For instance, a speech pathologist (service 3) commented:

We have to be really careful not to put another pressure on them and be unrealistic about what we are expecting parents to do at home, but at the same time, help parents understand that they really do need to make some changes and do some support work at home. They're good outcomes for the child but we have to be really careful in getting the balance right; that we're not just overloading the family that is already not coping and is already in crisis.

Given the changing roles occupied by the professionals, the creation of a partnership between each professional and the family was considered to be a necessity in optimising service delivery, echoing recent literature (e.g., Keen, 2007). For example, a senior physiotherapist (service 1) asserted, "if you don't get that communication [with families] at

whatever level – emails, phone calls, whatever – if you don't get that communication right, you'll be battling to get any [therapy] programs to work for that child". Furthermore, some of the services provided information sessions and written materials for families and training for their therapy staff to be skilled in communicating to clients and families. One senior speech pathologist (service 1) stated that her service provided "a lot of training about how to talk to parents, how to involve dads, and that sort of thing so I guess all those things contribute to us being more family-centered".

A third aspect of professional identity that challenged participants was whether or not advocacy work and community education are part of their role. An occupational therapist (service 1) stated, "I see [it] as the therapists' role but not everyone does. Some people see it more as the role of a social worker, so the professional boundaries are a bit of a struggle". Many participants wanted their services to further emphasise prevention, community education, and community development in order to "empower parents so that they've got the skills and they don't require qualifications other than being a mother with an ability to do fantastic things with their children at home" (speech pathologist, service 3). For example, in describing her role as a consultant on the development of an accessible local playground, an occupational therapist (service 2) asserted, "we're very much out there in the community, educating people, and being involved in the provision of those sorts of services in the real world".

Finally, the professionals' negotiation of their changing professional identity was at times fraught and complicated by the requirement for them to become increasingly involved in the whole lives of clients and their families. As such, many of the allied professionals spoke of the importance of self-care so they do not risk empathy fatigue (Stebnicki, 2007) or take home the emotional labour (Hochschild, 1983) of their work. A senior speech pathologist (service 1) commented that working with a child with disability "is not easy, and

you know that that child is always going to have a permanent disability... So you can take some of that home with you” while a physiotherapist (service 2) observed:

Sometimes you have to spend that extra time. So that’s the challenge – fitting everyone in, and that can be pretty tiring and exhausting, and have an emotional burden on you too and you feel empathy for them. I mean if it’s a particularly hard situation for them, it’s hard to leave that behind when you go home at the end of the day. So learning to do that is a pretty big challenge.

Professional Challenge 2: Working Collaboratively with Therapists from Different Disciplines

The second professional challenge of moving towards a wellness approach involved the ways in which staff from different disciplines were expected to work together as a team with less reliance on hierarchy and a greater focus on collaboration and flexibility. A manager (service 4) described the team as moving towards embracing an explicitly collaborative approach so that a family is likely to be visited by “one therapist at a time so the speechie might be doing some physio work or some OT work”. However, the therapists within the three remaining services were challenged at times by the requirement to work together in a similar way and to the same end. Instead of working harmoniously, one speech pathologist (service 2) described the interactions of therapists across disciplines as sometimes consisting of “all the therapists around the table with parents fighting over what the priorities might be”. The ‘competition’ and poor communication between team members (Malone & McPherson, 2004) was thought to be fuelled by physical separation between therapists of different disciplines within the building, which was a remnant from when the services adopted a medical approach. The separation of the services along discipline lines is particularly perplexing for families yet one physiotherapist (service 3) commented that working collaboratively across discipline-specific services:

...is a bit of a process because each of those services has its own waiting lists, so if we were waiting for somebody to get assessed quickly, it's not fair on the children on their waiting lists to have somebody jump in ahead of them, so it's a hard thing to ask another professional to prioritise somebody over the children [who] are already waiting. It's hard.

Similarly, the participants were challenged at times when working with professionals outside of allied health. As part of their role, some of the participants also liaised regularly with doctors, nurses, teachers, and teacher's assistants. It was thought that a wellness approach was not well-understood or embraced by many of these professionals. For instance, reinforcing the dominance of the medical model in the health professions, a psychologist (service 3) commented that, "doctors and nurses...want a diagnostic medical category. They'll have diagnostic categories and it's very clinical, but when you say wellness, it's too general. It's just how they think and how they're trained". An occupational therapist (service 1) commented, "the TA [teacher's assistant] comes out [of training] and the therapist goes to works with the TA and they've got an ingrained idea about the child, and the therapist has to spend two hours re-educating the teaching assistant". Similarly, a social worker (service 4) commented that teachers she works with are, "very education-focussed and they're just not holistic, they're unbelievably not holistic. Their approach to early intervention is bizarre". These schisms in understandings of how best to work with children with disabilities and their families may lead to conflict between professionals.

Technical Challenge 1: Balancing Quality with Economic Imperatives

The first technical challenge centered on attempts to balance the desire to provide quality wellness services with the economic imperatives that permeate healthcare services (Grbich, 2002). Participants from the four childhood disability services stated that their services are faced with financial imperatives that underpin and direct service delivery, and it

appeared that some decision-making processes were driven by these economic constraints. For example, one manager (service 1) spoke of the utmost importance of meeting deadlines, key performance indicators, and targets in order to secure future funding contracts. He noted the tension that arose from, “balancing [wellness] with the demands of the business, because although it’s not-for-profit it is a business and we need to be viable”. Similarly, an occupational therapist (service 4) noted the importance of “striking a balance between the practical realities of human resources and financial resources” while a psychologist (service 1) described the practical difficulties of achieving:

...that balance between the resources and providing that quality service and having time to really explore family issues; I think that’s really hard. I know that when I’m working with families I really feel that time pressure that you’ve got to get to the point and have an outcome that’s measurable (sigh).

Some participants acknowledged that allied health practice in general and wellness approaches in particular lack the longstanding rigour enjoyed by other scientific, evidence-based disciplines such as medicine. Given the reliance on ‘objective’ measures of performance in evaluating and funding service delivery (Healy, 2002; Willis, 2002), this dearth of evidence impacts negatively on the ability to source funds for wellness initiatives. The participants spoke of the need for more research to enable them to evaluate their wellness approaches in order to be able to provide evidence of the efficacy of their services. As one manager (service 4) stated “we just don’t have the time or resources [to conduct research] but it would make a huge difference at the other end to give us some evidence... We don’t have evidence at all apart from anecdotally” while a social worker (service 3) commented that the funding body “certainly find[s] it hard to find a statistical way to count community development work so there’s that sort of trap I suppose of needing to attend to individual people and the other stuff...just gets left by the wayside”. In addition, the lack of time and

resources to conduct research coupled with the need for evidence was characterised as “a vicious circle” (Manager, service 4). According to another manager (service 3), the net result is that governments and other funding bodies “think ‘these guys [the childhood disability services] haven’t got a clue. They don’t know what they’re talking about. Their data collection’s on bits of paper in filing cabinets’.”

The economic imperative underpinning the services means that, in some instances, therapists reported having large caseloads and participating in unpaid overtime, which are characteristics of allied health roles in the disability sector more generally (e.g., McLaughlin, Lincoln, & Adamson, 2008). Some therapists described an organisational and professional culture whereby allied health professionals take on and/or are expected to take on the workload. For instance, a senior physiotherapist (service 1) questioned, “When does it stop? And we’re told you can say ‘no’ but it’s like, the families and children have needs (trails off)” and a social worker (service 2) commented on the “general consensus in the disability sector that everybody will take a huge caseload”. Outcomes of this type of organisational culture include reductions in employment satisfaction and staff morale and escalations of staff burnout and turnover. As one manager (service 1) described, “Turnover is a significant cost. High turnover, recruitment, and retention, is extremely important to us... Staff morale and drops in turnover rates are crucial to running our organisation”.

A small number of participants suggested that the economic constraints could be sidestepped by encouraging parents to shoulder more of the responsibility for treatment and care of their children, mirroring the notion that service providers often conflate family involvement in care for responsibility for it in order to transfer workload from the services to the families (Dodd, Sagers, & Wildy, 2009). For instance, one manager (service 1) stated that “the whole model of trying to get families to do a lot of the work at home as well has

really alleviated some of that [workload pressure]”. Similarly, another manager (service 3) asserted:

Traditionally, I think this business has been very much about the team or the therapist taking on the problem of the child and the family and helping to sort it for them. I think it has to change. I think it has to turn around and say “Well this is your problem. This is what we reckon you should do. We can provide you with this expertise and this guidance but you know, it’s your problem, you’ve got to sort it”...because otherwise there is never going to be enough allied health practitioners...to service the population if we stick with the model we’ve got at the moment.

Clearly then, these participants described the challenge of implementing a wellness approach into services underpinned by economic constraints.

Technical Challenge 2: The Speed of Change

Finally, the participants were challenged by the timeline expected by their services in translating wellness concepts into practice. While change is a long-term process, the therapists stated that they were faced with the expectation for almost constant change and at times, the speed of change was overwhelming. They recognised that genuine cultural change required a “comfortable lead-up time” (senior physiotherapist, service 1) and “getting everybody to be able to understand it” (psychologist, service 4) otherwise the change could result in “a lot of pressure on staff” (senior physiotherapist, service 3). The participants understood that changes in policy require time and support for them to transfer into practice. They also recognised that embedding innovation, such as a wellness approach, requires an organisational culture that fosters characteristics such as respect, trust, support, open communication, organisational stability, managerial transparency, a shared purpose, job satisfaction, and a real reduction in workloads. The participants seemed well aware of the key

issues highlighted in the literature devoted to cultural change in the workplace (e.g., Scott, Mannion, Davies, & Marshall, 2003). The constant change may be the catalyst for feelings of cynicism or resentment at times, consistent with notion of reform fatigue (van Eyk, Baum, & Houghton, 2001). A social worker (service 1) described the feelings that can arise as a result of continual change:

You get to point where people have had so many changes that they're just blasé, they're cynical, they're not buying to it, they just think "okay, it's just another change", you know, so while on the one hand that can look relatively positive because people are accepting and they're trying their best to do it, there's some sort of oh I don't know, sadness might be too strong a word but there's some resentment to it, you know. They just think, "Oh, I'm so tired of changes".

Discussion

The data demonstrated the professional and technical challenges encountered by allied health therapists in attempting to embed wellness approaches into their policies and practices of four different childhood health and disability services across Australia. Despite the diversity across the four services (i.e., specific or multiple impairments, government or not-for-profit non-government agencies, metropolitan or state-wide, and occupying various locations throughout Australia), the data demonstrated that practitioners from all four services encountered similar challenges in embedding wellness approaches into their practice. The professionals were at times challenged by negotiating the implementation of wellness within a sector that remains influenced by medical models of disability and constrained by neoliberal economic regimes. Wellness approaches are not (yet) routine in childhood disability services; however, we are buoyed by the evidence demonstrating the ways in which the therapists negotiate the varied and often conflicting tensions. The findings have

implications in determining how wellness approaches to health and disability may be best embedded within childhood disability services, allied health practitioner training, and research, and these are outlined below.

Implications for Service Delivery

Wellness approaches to health and disability are radical alternatives to the medical model. Despite theoretical, empirical, social, and political support for wellness approaches, the rhetoric remains largely misaligned with practice within the health and disability sectors. Embedding wellness approaches into health and disability services requires observable changes to professional practice, not just a change in the terminology and rhetoric used (Northway, 1997). Furthermore, once these changes are implemented, the real challenge then becomes sustaining them over time (Santangelo, 2009). We need to recognise that change is a process requiring multiple strategies at multiple levels, including the policies and practices of health and disability settings, the education and training of allied health professionals, and issues impacting upon allied health professions, not just a change in one of these. Despite an authentic desire by the services to do the best for clients and their families, a wellness approach cannot be implemented without attention to the facilitators of change (e.g., practitioner skills and adequate training, organisational stability, funding models that recognise wellness outcomes) and barriers to change (e.g., clients expecting a medical approach, an organisational culture unsupportive of the innovation, uncritical deference to and acceptance of medical discourse) at each of these multiple levels. For example, state and federal governments often use the rhetoric of wellness yet continue to fund services from a medicalised, clinical, and ‘repair’ approach (Bowles, 2001; Goggin & Newell, 2006), and this schism was reflected in our data. Additionally, wellness approaches should not be embraced as ways to transfer further therapy and further responsibility to parents. It is perhaps not

surprising then that within childhood disability services, the rhetoric of wellness is more easily identified than the practice.

For wellness approaches to be implemented into practice, we require a systemic and coherent framework that aligns with the economic imperatives that presently underscore childhood disability service delivery; otherwise wellness (like any other innovation) can only be practiced in 'bits and pieces'. Clearly wellness is present at the rhetorical and philosophical levels and components of it are evident in practice but the conceptual links between strategic plans/programme logics and practice and performance measures are underdeveloped. The development and implementation of a wellness framework and its strategies will require working partnerships between researchers, practitioners, managers, funding bodies, legislators, and clients and their families. Further, the change, especially if implemented effectively (i.e., the rhetoric is truly reflected in practice and these required partnerships are enacted), is likely to be slow. The work of researchers investigating how innovations in health care can be incorporated into practice is particularly instructive. For instance, while some therapists report being able to embrace wellness approaches more easily than others, our data show that it is clearly not sufficient to rely solely on individual therapists to move towards embracing wellness. Instead, these therapists need to be appropriately trained and supported to work in functional inter-professional teams, with the appropriate time and resources to implement the changes effectively, and encouraged to focus on their own self-care; these factors must be supported by the organisation's policies, management, funding imperatives, and empirical data (e.g., Grol & Grimshaw, 2003; Grol & Wensing, 2004). A recent study confirmed the importance of empirically-supported frameworks and procedures as key components of allied health professional practice; the authors examined the literature, surveyed over 600 allied health professionals, and conducted

focus groups with 71 service users to develop a comprehensive practice framework for working with children with Developmental Coordination Disorder and their families (Forsyth, Maciver, Howden, Owen, & Shepherd, 2008).

Implications for Allied Health Training

Training in the allied health disciplines needs to focus on producing therapists that are skilled, flexible, adaptable, well-respected, and able to deal with the uncertainties that come with constant change; these are the characteristics of high-calibre therapists (G. King et al., 2008). In addition, the training needs to encompass the notion and practice of wellness, enable working effectively with professionals from other disciplines, and include self-care so that therapists can keep themselves well in order to maximise benefits for their clients and families. Indeed, self-care practices for allied health professionals tend to be overlooked in the allied health literature despite the prevalence of burnout within several of these professions (e.g., Balogun, Titiloye, Balogun, Oyeyemi, & Katz, 2002; Lloyd & King, 2004). Allied health professionals need the knowledge, motivation, and training to enable them to incorporate wellness into their practice. Research has shown that providing information, incentives, and feedback, as well as the use of social marketing techniques, have been shown to have little effect in encouraging the uptake of innovation in healthcare practice (Wyszewianski & Green, 2000). Such a shift would include training the therapists to identify and remove barriers to the full participation in society of people with disabilities, and to perhaps place less emphasis on their assessment and treatment (Finkelstein, 2001) and more on advocacy and participation.

Implications for Future Research

It is important to consider the strengths and limitations of the paper in guiding future research. The various professional and technical challenges identified in this paper have implications for the quality and delivery of services and supports for children with disabilities

and their families. A key strength of the study is the diversity of services studied – multiple and specific disability, government and non-government, localised and state-wide, and across three Australian states – which facilitates the ability of the study to contribute to practice (Daly et al., 2007). However, it would have been beneficial to spend more time at each site to observe interactions between staff and with clients and their families, and perhaps gather parents' and clients' perspectives (Garth & Aroni, 2003). In addition, a longitudinal approach would provide the ability to track the implementation of wellness approaches over time. Furthermore, our decision to allow definitions of wellness to emerge inductively from the data rather than be defined at the beginning could have been explored in more detail to determine differences between therapists. While it appeared that the therapists' tended to self-define the term in a similar fashion, it was certainly possible for them to have significantly different ideas of what constituted a wellness approach. This included, for instance, some notions that focused on therapists' health and wellbeing and others which were clearly to do with clients' health and wellbeing (Breen, Saggars, Wildy, Millstead, & Raghavendra, unpublished manuscript). Finally, the participants identified research evidence they described as under-developed but needed for them and their organisations to practice wellness, such as information on successful inter-professional team building, strategies to overcome barriers to the implementation of wellness approaches, the economic benefits of wellness approaches, and optimising the therapists' self-care.

Conclusion

The analysis of data described in this report constructs a picture of the challenges of implementing wellness approaches in the policies and practices of four Australian childhood disability services. The study contributes to our understanding of how embedding a wellness approach into the policies and practices of allied health professionals within childhood health and disability settings may be hindered. Although based within Australia, the research may

be relevant to other contexts where the contemporary literature and current policy/practice is misaligned. In particular, although the aim of our study was to have practical benefit for the four services, the findings are likely to have general applicability to other services aiming to incorporate wellness approaches into their practices. We believe our study may provide insights into the challenges of providing childhood health and disability services that are empowering and that address issues of client wellbeing, individual choice, independence, and rights to meaningful and productive lives.

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Table 1

A Comparison of Medical and Wellness Approaches

Medical Approaches	Wellness Approaches
Elimination or cure of disease; emphasis on physical symptoms	A focus on holistic functioning and holistic definitions of health
The practitioner has the authority/is the expert	Shared control between client and practitioner
A 'one-size-fits-all' approach with limited to no flexibility	Individualised/tailored support, therapy and intervention
Services are provided by medical staff; where multidisciplinary teams exist, they defer to the medical expert	The use of multidisciplinary, interdisciplinary, or transdisciplinary teams consisting of practitioners from various health and allied health disciplines; power is shared
The provision of support from a hospital/medical setting	The provision of support from a community-based setting
Interventions are likely to be medical, surgical, pharmaceutical, or rehabilitative	Services include advocacy and/or the politicisation of health

Note: Adapted and extended from Breen et al. (2008).

Table 2

Process of Data Analysis

Stage	Purpose	Task
1	Validity: Accuracy	Verbatim transcription of audio files
2	Validity: Accuracy	Checking accuracy of transcription
3	Data analysis	Coding of qualitative data (interview data and field notes)
4	Data analysis	Thematising of codes
5	Data analysis	Relating themes to concepts from relevant research literature
6	Data synthesis	Integrating themes within discipline-based knowledge from literature
7	Data representation	Selecting illustrative examples of themes from qualitative data

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Appendix

Interview guide

The purpose of this interview is to find out about how wellness approaches are embedded in the policies and practices at [organisation]. I just want to remind you that the things you say will be treated in the strictest confidence and you won't be identifiable in the final report. I am particularly interested in your thoughts and opinions so please answer each question in your own words.

- Do you have any questions before we start?

First, I'd like to find out a bit more about you:

- I understand you are a/an [job title] here at [organisation]. Can you tell me about your background and experience in [allied health discipline]?
- What led you to working here at [organisation]?
- Can you tell me about your job and duties or activities here at [organisation]?

Now I want to move on to talking about the idea of wellness:

- What is your understanding of the term 'wellness approach'?
- How would/does a wellness approach improve service delivery/client outcomes, as opposed to other approaches?

Now I want to move on to discussing what wellness 'looks like' here:

- To what extent do you think [organisation] says it has (asserts) a wellness philosophy? Can you give me an example or a story to illustrate this?
- To what extent do you think [organisation] actually has a wellness philosophy? Can

you give me an example or a story to illustrate this?

- To what extent do you think you personally assert and practice a wellness approach in this organisation? Can you give me an example or a story to illustrate this?
- Can you tell me the impetus for wellness here and a bit about the history of how these practices were introduced and embedded into [organisation]?
- Do you think there's a difference in how wellness is talked about compared to how it's practiced here? Why? How so?
- Do you think the practice of wellness could be improved here? Why? How so?

Now I want to find out about your views concerning wellness:

- What do you see as the benefits of wellness approaches? To allied health professionals? To clients? Their families? To [organisation]?
- What do you see are challenges of wellness approaches? From allied health professionals? From clients? Their families? From [organisation]?

Thank you for participating in this interview today. Your answers have been really helpful to our understanding of wellness here.

- Are there other questions you wished I had asked you or anything else you wish to talk about?

We've come to the end of my questions. Thank you for your time.