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In search of wellness: Allied health professionals' understandings of wellness in childhood
disability services

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Keywords: wellness, allied health, children, families, professional practice, early intervention

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Abstract

Purpose. Wellness approaches are not routine in childhood disability services, despite theoretical and empirical support and an increasing demand for them from health consumers and disability activists. We aimed to investigate how health professionals define or understand wellness and its practise in the context of childhood disability.

Method. A qualitative, interpretive approach was taken. Semi-structured interviews were conducted with 23 health professionals (allied health therapists and managers) providing early intervention and ongoing therapy within four Australian childhood health and disability services. Years of experience providing services to children with disabilities and their families ranged from 6 months to 30 years ($M = 9.41$, $SD = 9.04$).

Results. The data revealed a noteworthy impediment to incorporating wellness into practise – the difficulties in the allied health professionals reaching consensus in defining wellness. There appeared to be distinct differences between the four services, while there appeared to be no appreciable difference based upon the individual professional's years of experience or allied health discipline.

Conclusions. The effect of organizational culture should be considered in efforts to embed wellness in childhood health and disability services in order to address client wellbeing, empowerment, choice, independence, and rights to meaningful and productive lives.

In search of wellness: Allied health professionals' understandings of wellness in childhood disability services

Wellness is generally defined as a holistic approach to health and emerged in parallel to the dissatisfaction concerning the medical model [1], the appearance of the social model of health and disability [2], definitions of health expressed by people with disability [3], and the recognition that consumers have a right to the primary role in their health care [4]. The holistic understanding of health underpins several key health policies including the United Nations' (1993) *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* [5] and the World Health Organization's (2001) *International Classification of Functioning, Disability and Health* [6]. Both policies emphasise the need for policies and services to address the social participation and equality of people with disability.

Community-based services [7], self-management and empowerment programmes [8], and family-centred practises [9] incorporate wellness approaches. Ideally, these models of service delivery define health as more than the absence of disease; encompass physical, social, psychological, and spiritual domains; feature informed choice, self-determination, and client-practitioner collaboration; and are symbols of the citizenship of people with disability [10]. It is important to note that wellness approaches do not diminish the impact of impairment or illness nor suggest that medical interventions are never effective or necessary; instead, medical services are best to be subsumed by an overarching wellness approach [11].

Wellness principles are embedded within various national health strategies and policies in Australia (and elsewhere), which argue for resources to be directed to public health approaches that improve quality of life rather than to acute care interventions in order to provide a healthy start in life, support families, encourage positive ageing, and maintain and improve the wellbeing of Australians. In addition, the shift towards wellness approaches to health and disability is supported empirically. Various studies demonstrate that wellness

approaches improve health status and behaviour, promote psychosocial well-being, increase client satisfaction with services, reduce hospitalisation, and are cost-effective [8, 12-15].

Furthermore, empirical evidence indicates that the efficacy of services based on the medical model may be limited across a range of domains and sectors [16, 17].

Current status of wellness in health and disability services

Despite the evidence cited above, the medical model remains the dominant paradigm for the training and practise of many health professionals [18, 19]. Despite disciplinary differences, however, practitioners tend to cite factors such as the increasing value of community-based service delivery, the reduction of therapist control and a corresponding increase in client control, and sociopolitical determinants of health, for the adoption of wellness and its components [20-22]. As a result, allied health professionals are left to reconcile the tension created from the increasing consumer demand for wellness approaches [23] with the health and disability sectors. For instance, a recent Australian study searched for indicators of wellness and demonstrated that the rhetoric of wellness is drawn upon heavily within the policy and procedure documents of major childhood disability services providing allied health services within Australia [24]. While none actually used the term ‘wellness’, the indicators of wellness – shared control between client and practitioner, holistic definitions of health, individualised support, multidisciplinary teams, the provision of support from community-based settings, and advocacy/the politicisation of health – were more likely to be evident in the non-government rather than government services. Importantly, it was not clear how each indicator was embedded within and enacted by the services in practise.

In order to examine the ways in which wellness is practised by allied health professionals, first we need to investigate how allied health professionals define wellness in the context of childhood health and disability. These understandings and definitions of wellness are likely to influence the ways in which it is incorporated into their practise. The

data are drawn from a larger study which aimed to determine how wellness can be embedded in the visions, policies, and practises of allied health providers working in childhood health and disability settings. We aimed to investigate how allied health professionals working in childhood disability services define or understand wellness and its practise in the context of childhood disability, as a first step towards aligning research and practise in childhood health and disability services.

Method

The research was a cross-sectional study using a qualitative, interpretive approach in order to capture the ways in which allied health professionals working in four childhood disability services defined or understood wellness and its practise in the context of childhood disability. Such an approach provides rich information that may be used to improve service delivery [25].

Sample

The sample consisted of 23 health professionals. Twenty-two were allied health professionals (5 social workers, 5 occupational therapists, 4 physiotherapists, 4 speech pathologists, and 4 psychologists) and one was a medical doctor. Five occupied managerial and policy roles within their organisation, and three of these participants also continued to deliver therapy as part of their role. The remaining 18 worked solely as therapists. The professionals (17 women and 6 men) ranged in age from their early twenties to early fifties. Years of experience providing services to children with disabilities and their families ranged from 6 months to 30 years ($M = 9.41$, $SD = 9.04$).

All of the professionals were employed within four childhood health and disability services in three Australian states – Western Australia, South Australia, and Queensland. The organizations provide allied health services to children either for specific ($n = 1$) or multiple impairments ($n = 3$) and either as government ($n = 1$) or not-for-profit non-government

agencies ($n = 3$). Two are state-wide services and two are localised to specific metropolitan areas. One service employs just over 100 staff members and another comprises approximately 275 staff members. The remaining services are appreciably smaller (one employed six staff members and the other employed eight) and situated within larger disability services. Access to the participants was facilitated by the study's partner investigator(s) located at each organization. These partner investigators purposefully identified the key personnel who were invited, via an information letter, to participate in a one-on-one face-to-face interview with the first author. Our instruction to them was to recruit to the study five to six employees – one from each allied health discipline they employed (physiotherapy, speech pathology, occupational therapy, social work, and psychology) and at least one manager. Five employees were recruited from Service 2 and six employees were recruited from the remaining three services. All professionals who were approached to participate agreed to being interviewed.

Data collection

Ethical approval was gained in March 2007 from the Edith Cowan University Human Research Ethics Committee and the data were collected between September and November that year. The allied health professionals were interviewed using a semi-structured interview guide [26]. The guide was trialled with the manager of client services at one of the organizations, and covered topics such as their understandings of wellness, beliefs about the factors that facilitate and impede the incorporation of wellness in their organization, and the practise of wellness within their organization (see Appendix). The allied health professionals were asked to provide examples from their practise experiences. 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. Open-ended questions and probes enabled the participants to provide answers. Care was taken so that questions were not double-barrelled

or leading and did not include double negatives, assumptions, or jargon. All interviews occurred within a private room at each workplace, were audio digitally-recorded, and took between 45 to 60 minutes.

Data analysis

Analysis began with the transcription, reading and re-reading of the transcripts and the interviewers' notes. Each transcript was checked for internal consistency [26]. Analysis was based upon the constant comparison process [27] to identify similarities and differences between individual participants, allied health disciplines, and across the four services. Rather than engaging in the process of simultaneous data collection and analysis until data saturation, time constraints for the site visits meant that the data for each organization were collected within a two or three day period and analysed as soon as possible thereafter. However, the interim analysis of transcripts led to further exploration of ideas in the next interview/organization visit.

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. These codes were then collapsed into categories representing different definitions of wellness (see Table 1). It was during this process that we noticed that there appeared to be no appreciable difference based upon the individual professional's years of experience or allied health discipline. The data did, however, reveal similarities between the employees within each service and the data are presented on a service by service basis.

[Insert Table 1 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. Preliminary analyses were also circulated among the research team and discussed during several team teleconferences with representatives from the four services. The draft report was disseminated to all members of the research team for comment in February 2008 and the final report incorporating their feedback was completed in May 2008.

Findings and Interpretations

Service 1

Service 1 provides a range of low-cost services for residents who are blind or vision impaired, and has a children and family services team specifically to meet the needs of children (birth to 18 years) who are blind or vision impaired. While the term wellness was promoted by this organization and features in its mission and slogan, there was resistance to the term from these participants, which was not identified in the other services. The term wellness was considered to be ‘a bit jargony’, ‘a bit airy-fairy’, and ‘like a made-up word’. These professionals equated wellness with illness and the medical model, which emphasises individual deficits that may be fixed [28]. As one explained, wellness implies that ‘something’s wrong to start with, and really there’s nothing wrong with these children, they just have vision impairment as one part of their life’ while another declared:

I think wellness implies illness and I wouldn’t necessarily see a disability as an illness so implying that you need to ‘get well’ doesn’t sit well with children... We’ve worked pretty hard to keep out the medical model (laughs) so to start using well and ill, it just doesn’t sit right...

Further, these participants asserted that wellness was more relevant to the provision of adult services than to children and family services. One participant stated, ‘To a certain extent that’s relevant to children but it’s not as relevant as it is to adults that have lost their vision’, while another asserted, ‘I’m struggling to really make the connection of wellness, or maybe

what I perceive wellness as being, and kids’. Another thought that wellness ‘doesn’t really apply to children as much per se... I just think with kids, they are well, they may have a disability but already they are well’.

After stating their clear reservations about wellness, the participants defined the term in two key ways. First, they defined wellness holistically and as encompassing a focus on emotional, social, recreational, and educational wellbeing, in addition to physical factors. According to one participant, the holistic nature of wellness meant that ‘it’s not just looking at a person or the child or the family from just one perspective. It’s looking at them from heaps of different perspectives’. Another participant stated that children with vision impairment are ‘not just a pair of eyes. Sometimes the doctors, the ophthalmologists, think of their patients like that, whereas we see them as a whole person’.

Second, the participants equated wellness with the empowerment of families and the identification of their strengths. For example, one participant asserted that wellness is ‘about empowering families to take some control of situations and...providing them with strategies or resources or networks to have a feeling of wellness for their family’ while another stated that wellness is about ‘trying to reach the full potential whatever that may happen to be, in a holistic sense’. Another asserted that ‘if you’re supposedly using a strengths perspective you’re finding other strengths for them too, and making them stronger in that sense’. Thus, at Service 1, wellness was a contested and debated term, was thought to align with the medical model, and was not considered to be relevant to children with vision impairment. At the same time, however, wellness was thought to encompass a holistic approach, promote empowerment, and identify strengths.

Service 2

Service 2 is a state-wide, non-government charity and the primary provider of free therapy and support to children with physical disability (birth to 18 years) and their families.

In contrast with the respondents from Service 1, these participants appeared to define wellness in opposition to the medical model of health and disability. Instead, their definitions were consistent with the World Health Organization's (2001) understandings of health and disability [29]. For example, one participant stated that a wellness approach means that 'the focus of your efforts is not on fixing up problems but striving for a state of health'. Another asserted that wellness is 'probably the furthest thing from the biomedical approach' while another stated that 'rather than that biomedical model of just fixing the client, it's more about external factors'. Another described wellness as being:

...a holistic approach to wellbeing, which is very different to a so-called old-fashioned medical model where sickness is to do with pathology and health is to do with absence of pathology. I think wellness is an approach where the whole person – and more than the whole person, the whole person's world – is taken into account in terms of how well they are... There are a whole range of factors apart from actual pathology or disability that affect how well we are.

Wellness as a contextual or systemic approach to health meant that service delivery should consider the child's family, school, and community contexts. These professionals described wellness as an approach that was directed by clients and their families rather than the therapist and cited the alignment of wellness with family-centred practice. Family-centred practice underpins service delivery for families with children with disability in Australia [30] and elsewhere. The approach recognises the key role of parents and carers in determining the priorities and needs of their children, and as such, the role of the professional then is to collaborate with the family and facilitate them in making informed decisions regarding the child's care. Our participants spoke of the importance of communicating and working with the family. One participant stated that wellness is about, 'understanding the family's whole

context and all of their needs, not just “the foot pedal on the wheelchair needs fixing” kind of thing’ while another described wellness in practice as:

...not just looking at the problem at hand but how it impacts on that person’s life. So if we’ve been called in to look at getting a child into the computer room at school, it looks on the face of it that it’s a matter of putting in a ramp or a rail or something, but of course until that’s done, there’s a big impact on that child in terms of interacting with peers and learning and being part of the group and all those other things that are very important for the child to be well in the whole sense. If they are excluded from activities, then it just contributes to that whole feeling of being different and being excluded, which doesn’t contribute to self-esteem and feeling like a whole person.

To consider each child’s family, school, and community contexts, the participants described wellness as requiring an individualised approach to clients and their families. An individualised approach is considered to be a central concept on health policy and service delivery for children with disability [31]. For example, one participant stated that ‘our clients are very individual and our services very individual-based, so our level of service response to all of our clients is very different from one to another’, another claimed that ‘all the parents are very different and the clients are very different’, while another provided the following example:

I could just go in and get a child a pair of splints when they’ve outgrown them but you really have to see if they’re not wearing their splints, why aren’t they wearing their splints? What other issues does the family have? And really trying to think laterally to try and help them with that situation, and when you go see a client, you have to always think about what makes

them different to [sic] any other client and what issues they have that will impact on what you're trying to do...

Finally, an additional aspect of the professionals' descriptions of wellness was directed at the self-management of clients and their families. They talked about promoting the resilience and empowerment of clients and their families so that they were better able to be self-sufficient in managing their lives. For example, one professional stated, 'rather than us coming in and doing the treatment and leaving, we're trying to educate them about it and providing all this psychological support for their own wellness'. In sum, wellness at Service 2 was defined as a holistic approach that addresses all areas of health rather than physical health in isolation. Wellness was perceived as distinct from the medical model and aligned with family-centred practice, emphasised individualised approaches, and aimed towards self-management.

Service 3

Service 3 provides therapy and support to children (primarily pre-school aged) with mild to moderate developmental delay, learning difficulty, and physical disability, and their families. Unlike the other services included in the study, Service 3 is provided by a state government health service and the director is a medical doctor. Within this service, the six participants appeared to primarily define wellness as synonymous with prevention and early intervention. One participant commented that 'prevention and wellness go hand in hand', another stated, 'for me, the wellness approach is prevention so therefore hopefully you don't see these kids down the track', and another commented that prevention and early intervention are warranted 'because we now realise that so many things that happen to adults have their origin in childhood. It seems logical to me that adopting a wellness approach is actually adopting a preventative approach'. The prevention focus meant that community education was an important component of a wellness approach. For example, one participant stated;

I also think it could be incorporated with prevention sort of stuff, educating the population about what's normal development and we do that a fair bit. [We] go out and give talks to schools, childcare centres, to say here's what you should be looking for and here's some ideas about how to help. I think that's all part of wellness.

Wellness was considered to be more than the absence of illness. As one participant stated, 'you may not have a diagnosis but you may not be functioning particularly well'. Instead, wellness was thought to be about identifying and building upon the clients' strengths as well as identifying and treating their difficulties. One participant asserted that 'the strengths of the wellness approach are...that we...communicate to the families that there's a whole lot more to life than just the things you can't do' while another thought that wellness encompasses 'working to enhance people's wellbeing. Rather than looking at their illness and their deficits, we're looking at their strengths and building on their strengths as protective mechanisms for their future'. Related to the future was the concept of advocating for the clients and assisting the parents to advocate for their children, especially within the school context. One participant stated, 'I think everyone in the team would be saying we need to advocate for the kids in schools, we need to be pushing for this. I don't know if that's a wellness approach or a common sense approach!'.

Wellness was conceptualised as a holistic concept concerning the delivery of care. For example, one participant thought of wellness as being about the health of multiple systems including 'mental health, physical health, you name it'. Similarly, in order to see 'the whole picture', the participants focussed on the child within his or her family system. One stated that wellness is about 'trying to be holistic and not just looking at the kid's behaviour but looking at their parents' parenting style, relationship, [and] mental health...as opposed to

[only examining] a child and their problem'. Another participant stated that a wellness approach is effective because;

You're looking at the whole, the full aspects of the child, their family, and their environment, and that's got to have much better outcomes than just looking at a very narrow area of disability. It would be pointless with the vast majority of our children, to bring them in here and work on whatever their disorder was and send them out the door, without looking at what was happening in their family, their ability to support them, what was happening in their schooling or their day care, the parents' knowledge and skills to be able to support the children and feel empowered to advocate for them throughout their schooling, which is what they're going to have to do. Without that, the bit of work we do on the disorder is just a complete waste of time.

This holistic approach meant that some of the participants reported not only focussing on the children who are referred to the service but also attending to the children's parents and siblings. One participant commented that 'if we're seeing a child that has got a problem and there are siblings that we now realise are at risk, we attempt to put things in place to prevent them from developing the same problem'. In sum, wellness at Service 3 was primarily conceptualised as aligning with prevention and early intervention, but was also thought to encompass a strengths-based approach, community education, and viewing the child within his or her family system.

Service 4

Service 4 is a non-government organization that provides free therapy to support children (birth to 18 years) with intellectual, physical, neurological or cognitive disabilities, and their families. All six participants within the service primarily defined wellness as a

feature of the organizational culture of their workplace. For them, wellness described an organizational culture that fostered respect, trust, support, open communication, stability, transparent processes, a shared purpose, and job satisfaction; provided professional development; promoted self-care; and allowed employees to maintain a work-life balance. These aspects appeared to be particularly important to these professionals, given that the service had undergone considerable operational change prior to the site visit in order to combat issues of staff turnover, high caseloads, and low morale. For example, one manager stated, ‘wellness to me is keeping in mind all the time the needs and requirements of (employees)...to ensure that they have a balance in their life, and that we also have a balance in our lives’ while another commented, ‘our staff turnover was high last year, compared to national levels, and obviously it has a direct relationship to wellness in the workplace’.

There was considerably less emphasis in this service on wellness as an approach to practise, therapy, or intervention with children with disability and their families than in the other services, with five of the six professionals’ definitions of wellness focussing on the culture of the organization. One therapist stated, ‘I don’t recall the use of that term wellness at (Service 4), and I hope other people have said similar things (laughs) or I’ve missed something!’ while another claimed, ‘I don’t think it’s overtly spoken of... We’ve got wellness days [for staff], but that’s pretty much the only time you’d hear that word wellness’. Interestingly, the most recently-employed professional defined wellness differently from the others who were interviewed and stated, ‘I think it’s moving away from just looking at the disability as something that we need to treat in a medical way to looking at the child’s whole life and where they fit in the bigger picture’.

When wellness was used to describe an approach with clients and their families, the descriptions focussed on characterising wellness as a holistic approach to health as opposed to illness and related to more than physical health. For example, one participant asserted, ‘I

guess our aim is to look at greater wellness and I think it's not just that medical type wellness, but also mental health of the family and the child...being well and together in a full way as well – physically, socially, and that sort of thing'. Additionally, there was an emphasis on viewing each child within his or her family, school, and environment systems. For example, one participant emphasised the importance of taking 'families as a whole' and another asserted the importance of recognising that 'the child belongs to a unit'.

Wellness was also defined as a focus on strengths rather than deficits. The professionals in Service 4 asserted that a strengths-based approach involves 'helping them (children and families) to celebrate the successes', 'always trying to see the positive side of things', focussing on 'the inclusion of those kids', asking, 'how can we help them participate in everyday life even more?', and emphasising what the client can achieve:

Children with disabilities are not necessarily going to achieve their developmental milestones by particular ages, so sometimes you can be working towards those kinds of goals but they're not really participating in general life or community or having a good time in the family. So we might work on a discrete skill but it's not very relevant. I guess the medical model is fixing those discrete problems whereas a broader approach is looking at the child's function, and practical things that they can do with their disability.

Wellness was also considered to be a process that facilitated the empowerment of the families by working with them towards self-management. The participants described their attempts to develop working relationships with families in ways that are enabling and assist the families to define and achieve their goals to ultimately become self-reliant and problem solve. For example, one participant emphasised the importance of 'working together' and creating 'a partnership' while another noted that her role involved 'helping them explore

different strategies, and making suggestions about how they could get ongoing assistance if that's what they need, or ideally giving them tools to help them problem solve things that could crop up in the future'.

Thus, wellness within Service 4 was primarily defined as a necessary focus of the organization wherein the organizational culture fosters respect, trust, support, open communication, stability, transparent processes, a shared purpose, and job satisfaction; provided professional development; and allowed employees to maintain a work-life balance. Secondary definitions of wellness encompassed a holistic notion of health, a strengths-based approach, and partnering with clients and their families.

Discussion

In this paper we presented data revealing the varied ways in which wellness is defined by allied health practitioners working in four different childhood health and disability services across Australia. If professionals are to embed wellness – the concept and its practice – into their everyday work with children with disabilities and their families, we argue that some consistency in their understandings is a necessary starting point. The data indicate that allied health professionals do not share a common definition of wellness; rather they define wellness in a variety of ways, and in particular, focus on wellness as an approach to practise, therapy, or intervention with clients and their families. Their definitions highlighted concepts such as prevention, family-centred practise, a strengths-based approach, advocacy, the child as part of a family system, and wellness as more than the absence of illness. Interestingly, these understandings and conceptualisations were discernibly different between the four services, while there appeared to be no appreciable difference based upon the individual professional's years of experience or allied health discipline. Instead, the organization itself appeared to be the primary determinant of how wellness is defined and enacted within each service.

Our data inform a conceptualisation of workplace uptake of the notion of wellness among allied health professionals working in childhood health and disability services. There appears to be a common rhetoric across the services that wellness means holistic, implying both that the individual client is viewed as a ‘whole’ person’ rather than as a site for a disability, and also that the client is viewed in the context of a family or a community. Linked to this rhetoric is the notion of wellness as ‘strengths-based’, that is, that service providers attend to the child’s context and build on its strengths. However, despite some overlap in understandings across the four sites, there seems to be some stark variations and these relate to the participants’ perception of how the rhetoric of wellness applies in their workplaces.

For the sake of our argument, we now extrapolate from the cases and propose a continuum of organizational wellness. The key construct here is the extent to which the wellness notion is deemed to be applicable to the allied health professionals themselves. At one end of the continuum, in such a conceptualisation, we suggest that professionals view the term to have little relevance to their conceptualisations of their service delivery. Indeed Service 1 might serve to illustrate the lack of resonance with the term wellness among professionals who go as far as to describe it as a ‘made-up word’ or jargon. They did, however, share an understanding of health as holistic, the promotion of empowerment, and the need to identify a family’s strengths. In such a culture, at best, the term itself is related to positive attributes of hope and optimism among clients. At the other end of the continuum is the organizational culture that explicitly values the wellness of its members as professionals. The emphasis in such a culture is on positive values of shared purpose, job satisfaction, trust, respect, and work-life balance. Service 4 provides an illustrative case of such a culture where what is sought for clients – namely, empowerment, self-management, resilience, and trans-disciplinary support – cannot be optimised unless also embedded in the everyday practises and routines of allied health professionals in their workplace.

Our insights from the four services leads us to believe that organizational cultures that support wellness for clients are those that also support wellness for professionals. For example, the notion that a wellness approach incorporates individually-tailored services for clients would be consistent with a workplace culture that attends to the individual needs of its professional staff, with flexible arrangements for different career stages and personal and family requirements. Previous research into the retention of allied health professionals points to the need for organizations to be flexible to cater for increasing demands for mobility among young employees who travel, change jobs, seek variety and career opportunities, and respond to professional challenges and responsibility [32, 33].

The notion of wellness in disability service delivery is gaining increasing theoretical, empirical, social, and political support, although its practice is not routine. The incorporation of any innovation into clinical practice and best-practice guidelines is a fraught process, marked by numerous facilitating and impeding factors requiring holistic and complex attention over time [10, 34, 35]. Recent studies have confirmed the need for practitioners to overcome habits and discomfort with change in order to facilitate the uptake of new practises [36] and the importance of empirically-derived frameworks for allied health professionals [37]. We propose a further difficulty stemming from the difficulties allied health practitioners have in reaching consensus in defining wellness. We have identified a ‘silo’ effect, wherein wellness and its applications to practise appear to be organizationally-determined rather than shaped by other potentially key factors such as discipline or years of experience. Clearly then, embedding wellness into childhood disability service delivery requires the alignment of literature, policy, and practise, and holistic and complex cultural change in therapy practise; organizational leadership, policy, and management; and practitioner training (university and beyond).

We argue in this paper that although various disciplines may have come to the notion of wellness along different paths, when allied health professionals come together to provide health and disability services for children and their families, any variation is blurred in the workplace because organizational culture is always powerful. Culture, being the sum of the small everyday routines and practises of group members, is, by its nature, implicit, taken-for-granted, and rarely challenged by those who live it. Culture is persistent and difficult to change. We believe that those organizations that would embed wellness in their professional services to clients would be wise to look to their own professional practises, challenging those that do not align with the rhetoric that they espouse.

In this paper we were able to explore how wellness approaches are conceptualised by allied health practitioners working in childhood health and disability services across Australia, which will assist the larger project's aim of embedding wellness approaches by allied health professionals within childhood health and disability services. A shared wellness framework across services and disciplines would provide an important step towards allied health service provision that is empowering and that addresses issues of client wellbeing, individual choice, independence, and rights to meaningful and productive lives.

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Dr Raghavendra is employed at one of the services from which data were derived. The remaining authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Table 1

Definitions of Wellness used by Health Professionals in Each Service

Service	Definitions of Wellness
1	Wellness as illness Wellness as physical, emotional, social, recreational, and educational wellbeing Wellness as empowering and strengths-focused
2	Wellness as promoting health Wellness as family-centered practice Wellness as an individualized approach Wellness as promoting self-management
3	Wellness as prevention and/or early intervention Wellness as community education Wellness as strengths-focused Wellness as mental, physical, and familial health
4	Wellness as an characteristic of their organization Wellness as physical, social, mental, and familial health Wellness as strengths-focused Wellness as a working relationship

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.