



Rialtas  
na hÉireann  
Government  
of Ireland

# Health Service Supports

for Children with a Disability  
or Developmental Delay  
attending the Early Childhood  
Care and Education Programme



Seirbhís Sláinte  
Níos Fearr  
á Forbairt

Building a  
Better Health  
Service

An exploration of health service supports provided for children with additional needs attending the Early Childhood Care and Education Programmes in Ireland, benchmarked against evidenced based best practice (March 2017)

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- Health Service Executive
- Department of Health
- Department of Children and Youth Affairs

## Abbreviations

AIM	Access and Inclusion Model
CCC	County Childcare Committee
CHO	Community Health Organisation
CDNT	Children’s Disability Network Team
DCYA	Department of Children and Youth Affairs
DES	Department of Education and Skills
DoH	Department of Health
ECCE	Early Childhood Care and Education
HSE	Health Service Executive
IDG	Inter Departmental Group
LIG	Local Implementation Group (or Governance Groups where Early Intervention Teams are already established) who analysed the survey.
OT	Occupational Therapist
PC	Primary Care
PDS	Progressing Disability Services for Children and Young People
SLT	Speech and Language Therapist

## Executive Summary

### Purpose and Background

An innovative model supporting children with disabilities to access and meaningfully participate in the Early Childhood Care and Education (ECCE) programme was announced by an Interdepartmental initiative in 2015. This prompted the establishment of a project group tasked with ensuring successful integration and implementation of the model across three government departments. The model is led by the Department of Children and Youth Affairs (DCYA) and involves the Department of Health (DoH), and the Department of Education and Skill (DES) and their respective organisations including the Health Service Executive (HSE), Better Start, City/County Childcare committees (CCCs) and Early Childhood Ireland (ECI). The model is referred to as Access and Inclusion Model (AIM).

AIM includes a programme of supports for children escalating from universal inputs for all children towards targeted input for children with additional needs. AIM is a needs and strengths based approach, recognising that children and families experience positive outcomes while supported within an integrated and inclusive system. The system plans to draw from expertise within the sectors mentioned above. The model is based upon a firm foundation of guiding principles that are aligned with health service features associated with successful outcomes for children and families.

AIM has seven levels. These levels are depicted in the diagram below.



This review was undertaken by level 6 Health Service Supports Working group to

- a) assist in establishing the baseline of supports that are currently provided by early intervention services in mainstream preschools supporting the access and participation of children with disabilities and
- b) to establish models of best practice for early intervention services collaboration with parents and early education services.

AIM Level 6 Health Service Supports Working Group acknowledges the excellent practice occurring nationally with respect to the provision of support to both children and families and their preschool placements as evidenced in Section 2; Results of the Survey.

A rapid desk top literature search, (in this case a search conducted over a short space of time) indicates that there are several core components of early services associated with positive outcomes for children and families.

**Core components of early services associated with positive outcomes for children and families**

- Family Centred Practice
  - *Natural context*
  - *Key Stage transitions*
  - *Access to Information*
  - *Key Point of contact*
- Outcomes based
- Interagency collaboration
- Evidence based
- Governance and accountability
- Systems based on guiding principles and values

## Recommendations

- Interagency collaboration between government departments and agencies with a remit for supporting children with a disability. As the National Early Years Strategy is being developed, collaboration with health services early intervention services is strongly recommended.
- Services should continue to adhere to a Family Centred Approach, supporting children and families in an integrated coordinated manner.
- Strategies utilised to support children with a disability and their families should demonstrate a robust evidence base.
- Health Services are encouraged to adopt an outcomes based approach as indicated in the *Outcomes for Children and their Families Framework, an Outcomes Focused Performance Management and Accountability Framework for Early Intervention and School Age Children's Disability Network Teams* (HSE, 2013).

## Implications for Health Service Providers Practices

- Strengthening of supports during key transition for children with disabilities and their families e.g. preparing for preschool, primary school.
- Services must continually evaluate practices / supports ensuring an adherence to guiding principles and values, and evidence base.
- Specific instructional practices for children with a disability need to be evidence based, adapted to and embedded in, Early Years curricula and daily routines.
- Specific instructional practices require regular monitoring and review to ensure they continue to meet the child with disabilities needs.
- Fidelity of implementation of practices/training paramount.
- Continued awareness of the significance of the health clinician - client relationship and its impact on child and family outcomes.

## Introduction

Children's disability services in Ireland are undergoing an unprecedented change in service delivery under the national reconfiguration programme, *Progressing Disability Services for Children and Young People* (PDS). Its key objective is to ensure equity of access to services and supports for all children with a disability based on individual need, not diagnosis, where they live or go to school.

PDS is currently at different stages of implementation across the country. As a result the provision of health services supporting children with disabilities to access mainstream preschools are provided through several pathways. These include; Children's Network Disability Teams (CNDTs), individual disciplines working within primary care (PC) and HSE funded voluntary agencies.

Under AIM, Health Service interventions for Level 4, 5 and 6 will be provided when they are critical to enable a child with a disability to access and meaningfully participate in their ECCE programme. The definition of "critical" as agreed by the HSE, DOH and DCYA is:

*"Health services are considered critical to participation in the ECCE programme where it is reasonably agreed that a child, in the absence of those services, and taking into account other existing or available services and supports, is*

- 1. Unable to access the pre-school setting, due to environmental barriers,*
- 2. Unable to commence the ECCE programme,*
- 3. Unable to remain on the ECCE programme, or*
- 4. Unable to meaningfully participate in their ECCE programme*

*and that the provision of the particular services will help to ensure that the child can access and meaningfully participate in their ECCE programme.*

Evidence from the literature informs that an integrated system yields positive outcomes for children and families. In recent years there has been a shift from a child focused approach to service delivery towards a systems approach (ARACY, 2015). Children's developmental

goals remain at the core of this approach; however it is acknowledged that outcomes for the child are inextricably linked with the family system (ARACY, 2015).

The C4EO (Centre for Excellence and Outcomes in Children and Young Peoples Service, 2010) recommends that services provided to families and children with disabilities are embedded in naturalistic settings such as the home / school environment. A service addressing the family context with streamlined, integrated interagency collaboration is likely to yield the richest outcomes (Moore, 2012). Research suggests that access to high quality pre-school education can reduce subsequent special needs education diagnoses for primary school (C4EO, 2010). This requires access to evidence based intervention programs. Additionally information and a clear understanding of a child's developmental profile are vital. Building the capacity of parents, ensuring that they view themselves as paramount within the overall strategy for ensuring their child maximises their potential also reinforces the likelihood of positive child and family outcomes (Moore, 2012). Evidence indicates that services operating from the platform of quality service delivery, equity, evidence based practice and collaboration are considered the hallmarks of best practice (ARACY, 2015). In addition the impact of an inclusive culture cannot be underestimated. This review aims to provide a profile of service provision and integration between health led services and early care and education services supporting children with disability in Ireland.

## **Vision and Guiding Principles**

In 2005 the United Nations committee on the Rights of the Child underlined the importance of early childhood development (United Nations, 2006). The UN committee highlighted the importance of access to early education with systematic family involvement. It also notes an onus on governments to ensure the development of a comprehensive framework for early childhood services. One aspect of this quality framework in Ireland has been the rollout of the universal ECCE scheme for all preschool children. Early education programmes "should be comprehensive, focusing on the child's needs and encompassing health, nutrition and hygiene as well as cognitive and psychosocial development" (UNESCO, 2000, p.15). The World Bank (2013) indicates the main policy goals for early childhood development systems

include the establishment of an enabling environment, implementing the system widely and assuring quality through a monitoring system.

AIM reinforces early childhood education and health systems whereby children with disabilities are provided with an inclusive, developmentally appropriate and holistic early education experience. The IDS report *Supporting Access to Early Childhood Care and Education for Children with a Disability* (2015) underpins the assumption that all children, including children with a disability, shall be able to meaningfully participate in the ECCE Programme in mainstream pre-school settings (with some exemptions where specialised provision is required). It recognises the need for consistent, efficient and effective, equitable, evidence informed, high quality, inclusive, integrated and needs driven systems, in alignment with international policies on early education and inclusive practices.

#### **AIM Guiding Principles**

- *Consistent*
- *Efficient and Effective*
- *Equitable*
- *Evidence Informed*
- *High Quality*
- *Integrated*
- *Inclusive*
- *Needs Driven*

#### **PDS Guiding Principles**

- *Fair and Equitable*
- *Integrated*
- *Child and Family Centred*
- *Needs Driven*
- *Efficient and Effective*
- *Evidence Based*
- *High Quality*
- *Accountable*
- *Transparent*

These objectives are echoed within the HSE Corporate Plan 2015-2017 (2015) and the guiding principles identified for the AIM programme. The HSE espouse values, including Care, Compassion, Trust and Learning. HSE values encompass goals for the provision of the highest quality care and the delivery of evidence based practices. HSE services aim to provide fair, equitable, and timely access to quality health services. Moreover these

principles are consistent with the components of a service producing positive outcomes for children and their families.

**Vision for AIM Programme:**

*All children including children with a disability, shall be able to meaningfully participate in the ECCE Programme in mainstream pre-school settings (apart from exceptional situations where specialised provision is valid for reason unavoidable), (IDG report 2015 Pg. 10*

## SECTION 1

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# LITERATURE REVIEW OF BEST PRACTICE MODELS IN EARLY INTERVENTION

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## **1.1 Introduction**

Section 1 presents information from a rapid desk top literature review on best practice models in early intervention.

## **1.2 Methodology**

A broad literature search was conducted to inform this report. Information was gathered from journal articles, policy documents, reports, books, and databases. In addition internet search engines were utilised. This included the browsing of specialist international websites for early interventions and early education. The HSE library conducted a literature search using terms early intervention, Inclusion, special education, early childhood, preschool, Speech & Language Therapy, Occupational Therapy, Physiotherapy, education. The information gathered was then analysed and synthesised in this paper.

## **1.3 Effective Early Intervention**

Effective, evidence based early interventions have been identified as the most promising strategy for changing the trajectory of children's lives (ARACY, 2015). There is no "silver bullet" or one single model identified when defining and designing effective early services (ARACY, 2015, C4EO, 2010). In recent years there has been a shift in early intervention services from a child focused approach to service delivery towards a systems approach (ARACY, 2015). Children's developmental goals remain at the core of this approach, however it is acknowledged that outcomes for the child are inextricably linked with the family system (ARACY, 2015). Early interventions should occur in natural settings. A child's natural setting provides enhanced opportunity for learning opportunities that will serve to support development (Bruder, 2010). Early services must be embedded within an integrated service framework encompassing strategic leadership at both national and local levels, activate evidence based practices, demonstrate an outcomes focus and have a basis in family centred practice (ARACY, 2015, Moore, 2011, Bruder, 2010).

The overarching goal of children's services is to enhance participation and the contexts in which children develop (King et al., 2002). Participation is defined as involvement in a life situation (WHO, 2007).

Meaningful participation in everyday life situations is the engine of development and the key to attaining a true sense of belonging and a satisfactory quality of life. Children with disabilities face many barriers to meaningful participation. Access to life experiences and opportunities necessary to develop the capabilities enabling children with disabilities meaningfully participate in their life situations may be restricted. In order to overcome these barriers children with disabilities require inclusive environments and specific supports from families, early childhood professionals and early intervention services (Moore, 2011).

This section examines the evidence for each of these core components of practice and combines this with information received from health services in Ireland with a remit for supporting children in the early years. It also considers the levels of integration and collaboration that currently exist between health services and early education providers while supporting children with additional needs participate in early education.

### **KEY MESSAGES**

- *No one single model has been identified as definitive in the delivery of Early Intervention*
- *Meaningful participation in everyday life situations is the engine of development*
- *Children with disabilities require inclusive environments and specific supports from families, early childhood professionals and early intervention services*

**Service features associated with successful outcomes for**  
**children and families**

***Service Features associated with successful outcomes for children  
and families***

- *A service based upon a set of values and guiding principles*
- *Family Centred Practices*
- *Integrated interagency collaboration*
- *The utilisation of evidence based intervention*
- *Clear governance and accountability*
- *Outcome based*

#### **1.4 Why intervene early?**

The early years have been identified as a critical time during which the foundations for healthy development are laid (ARACY, 2015). There is an emphasis throughout the literature on the significance of early brain development, positive life stimulation and the correlation with subsequent health, wellbeing and coping skills. Participation in high quality early childhood care can be a determinant of later educational success and life-long learning (C4EO, 2010). During early childhood, brain connections develop and recede in accordance with experience (Her Majesty's Government, 2011). The preschool age has been identified as a period of substantial growth and learning in terms of cognition, social-emotional and physical development. Access to quality, integrated early education and health services is crucial for children with disabilities to ensure the maximisation of their meaningful participation. Research indicates that the access and inclusion of children with disabilities into mainstream early education settings, impacts not only on their developmental profile but also positively impacts on their typically developing peers (UNICEF, 2012).

Early Intervention has been defined as:

*Multidisciplinary services provided for children from birth to five years of age to promote child health and wellbeing, enhance emerging competencies, minimise developmental delays, remediate existing or emerging disabilities, prevent functional deterioration and promote adaptive parenting and overall family functioning. (Shonkoff, Meisels, 2000)*

Dunst and Trivette (2009) propose an alternative definition:

*Early childhood intervention and family support are defined as the provision or mobilisation of supports and resources to families of young children from informal and formal social network members that either directly or indirectly influence and improve parent, family, and child behaviour and functioning. The experiences, opportunities, advice, guidance, and so forth afforded families by social network members are conceptualised broadly as different types of interventions contributing to improved functioning.*

Dunst (2007) challenges Shonkoff and Meisels definition and proposes the inclusion of naturally occurring experiences and opportunities offered to families can be conceptualised as ‘interventions’ contributing to improved functioning and participation for children with disabilities. Dunst’s definition focuses on the parents and family capacity as a means of strengthening child functioning (Dunst et al., 2005). Both definitions highlight collaborative practice across agencies and systems. Outcomes are accomplished by **individualised** developmental, educational and therapeutic services for children provided in conjunction with mutually planned support for families (Shonkoff, Meisels, 2000).

ARACY (2015) indicate that the evidence for investing within prevention and early intervention is indisputable. Heckman (2008) notes that although it is possible to remediate rather than intervene early, this tactic is significantly more costly both financially and socially. Manning et al. (2011) report that early years prevention programmes had a significant impact on positive outcomes such as educational success, cognitive development and social emotional development. C4EO (2010) completed a review of 17 studies from the UK, USA, Canada, Australia and the Netherlands. This review concluded that effective

preschool education can reduce the likelihood of special educational needs in primary school. In addition it notes that effective early intervention addresses the family context.

Studies have indicated that the development of social-emotional regulation and secure attachments at an early age impact on a child's wellbeing into adulthood. This principle is underlined in the British Governments report *Every Child Matters* (2003) and The British Government's review *Early Intervention: The Next Steps* (2015). The *Next Steps* (2015) report reiterates the significance of social-emotional development in the early years and calls for continued investment in this area of early intervention. ARACY (2015) report that programs supporting the development of self-regulation and resilience skills have been successful in building social emotional well-being, leading to positive long term outcomes.

Considering prevention and early intervention as means of maximising human capital is not a novel concept (ARACY, 2015). *Better outcomes, Brighter Futures* (DCYA, 2014), Irelands national policy framework for children and young people aims to achieve positive outcomes for children and young people through addressing inequalities within society and breaking cycles of intergenerational disadvantage. Positive outcomes for families and children are assumed to enhance social inclusion, interrupt cycles of disadvantage and inequality, thereby reducing levels of social dysfunction (ARACY, 2015).

The long term economic benefits for society have also been cited as an impetus to invest in early interventions and universal prevention programmes. The Victorian Government in Australia concluded that universal supports such as maternal child health versus remedial supports such as out of home care were far more cost effective per individual than later remediation (DEECD, 2013). A study completed by Lee et al. (2008) examining the impact of early child welfare programs based on efficacy and cost effectiveness concluded that a significant financial benefit can be yielded both in personal terms for the children involved and to the taxpayer. Additionally in Britain the New Economics Foundation and Action for Children have estimated that investment in evidence based targeted and universal interventions could save substantial sums of money over the lifetime of a child. Of note investment in targeted interventions would yield the quickest return (Aked et al., 2009).

## 1.5 Impact of failing to intervene early

Timely access to evidence based intervention programmes significantly improves life outcomes for children (Shonkoff JP, 2010). A report on Community Healthcare Organisations discusses the need for integrated care (HSE, 2014). This report indicates that health professionals can provide better access and quality local decision making through working together. Early childhood education is considered a universal platform for all children (DCYA, 2015). AIM is an example of progressive universalism and provides reinforced support for children with the greatest need.

Accessing early interventions has been characterised as difficult and challenging for caregivers (Foran, Sweeny, 2010). Parents of children with Autism Spectrum Disorder report increased parental distress in comparison to parents of children that are typically developing (Hayes, Watson, 2013). Children with a physical disability encounter physical, social, and institutional barriers to participation in various life roles (Boyd et al., 2013). Hastings et al. (2005) note that a parent whose child has an intellectual disability experiences higher levels of stress than parents whose child does not have an intellectual disability. Reichman et al. (2008) report that parents of children with additional needs are more likely to experience increased financial pressures and poorer mental health.

Families and children who access services in a timely manner are less likely to encounter professional client break down (Dempsey et al., 2008). Additionally it has been acknowledged that early intervention is imperative to support the development of children with disabilities and therefore timely access is crucial (Silverstein et al., 2006). Dempsey et al. (2009) indicate that the manner in which professionals support families and children with disabilities impacts on child and family outcomes. Glascoe (2000) reports children who have accessed early intervention are more likely to complete school, maintain a job and live independently. Access to services and resources is an important factor in supporting family's ability to cope with a child experiencing a disability. This evidence highlights the critical importance of working with families to build their capacity to connect and care for their child (ACT, 2014).

## ***Key Messages for Early Intervention***

### **Benefits of intervening early**

- *Early Intervention significantly improves the outcomes for children and families*
- *Effective, quality preschool education can reduce the likelihood of a diagnosis of special educational needs in primary school*
- *Programs focusing on the development of resilience and self-regulation skills lead to positive outcomes for children and families*
- *Economic benefits*

### **Failure to intervene**

- *Can lead to increased levels of stress for families-impacting on outcomes*
- *Can lead to poor parental –professional relationships*

## **1.6 Family Centred Practice**

Family centred practices have been identified as one of the characteristics of an effective early service. Family centred practice is defined as:

*A set of values, skills, behaviours and knowledge that recognises the centrality of families in the lives of children and young people (State Government of Victoria, 2012)*

Disability services in Ireland are underpinned by this concept. The ***Outcomes for Children and their Families Framework*** (HSE 2013) promotes family centred practices acknowledging the integral part the family system plays in positive outcomes for children. Family-centred approaches have been widely adopted in services supporting families and children over recent years. Family centred practice is evident in government policies for children's services in Australia, New Zealand, Canada, the United States and United Kingdom (Dempsey et al., 2009). Literature is indicating a shift from clinic based, discipline specific, professionally directed and informed by norms referenced assessment towards a family

centred, community based, interdisciplinary and partnership based and informed by functional assessment approaches (State Government of Victoria Guide for professionals, 2011). Family centred approaches to early intervention are reported to have a positive impact on parental self-efficacy. This in turn has an impact on parent child interactions which has been shown to have a positive impact on child development (Trivette et al., 2010).

### ***Key Messages for Family Centred Practice***

- *Ensure family centred practice is embedded in services guiding principles*
- *Adherence to family centred practices requires vigilant monitoring*
- *Children develop within the context of their families and naturally occurring roles and routines arising from this context*
- *Children with disabilities require maximum interventions not maximum services*
- *Promoting parental capacity impacts on outcomes for children*

The Irish government's publication **Right from the Start** (DCYA, 2013) asserts that parents have the primary responsibility for their children's upbringing. The profound impact that parents and families have on a child cannot be underestimated.

*Parents are the most important people in their children's lives. Children learn about the world and their place in it through their conversations, play activities, and routines with parents and families (Aistear, 2009)*

While family centred practices in early intervention are supported by a significant evidence base, Dunst and Trivette (2009) caution that the adherence to family centred principles must be continually monitored. In their study attempting to establish the extent to which staff adhered to family centred practices, they found that over a period of 14 years there was a significant variability in observance of family centred principles. Data must be collected and analysed regularly to inform practice and maintain quality.

Early Services should be delivered in the child's natural surroundings and address the family context.

## 1.7 Intervening within a Natural Context

Children develop within the context of their families and naturally occurring roles and routines that emerge from this background (Bruder, 2010). Children spend the majority of time with their families engaged in daily routines, roles and activities (Bruder, 2010). It is estimated that the 1-2 hours that an early Intervention clinician may spend with a child is likely to represent less than 3% of their waking week (Moore, 2012). The majority of a child's learning occurs between direct therapy sessions, not during them (McWilliam, 2010). Hence natural and inclusive learning environments can contribute to the delivery of instructional practise and therapeutic techniques as these strategies can be easily embedded into naturally occurring activities and routines (Bruder, 2010). McWilliam (2010) concludes that it is maximal intervention the child needs, not maximal services.

Parents, play and home environments are critical to child development and positive outcomes. Early experiences can enhance or diminish innate potential. ARACY (2015) conclude that parenting is so influential that it has the capacity to moderate the impact of social and economic disadvantage. Healthy development is dependent on positive nurturing relationships within the context of primary caregivers. Research has demonstrated that children who have secure attachment relationships are better able to regulate their emotions and experience empathy (Panfile and Laible, 2012). Secure attachments have been identified to have an impact on a child's emotional regulation social and behavioural adjustment, peer relationships and school achievement (Barlow, Blair, 2012). Promoting the importance of parent–infant relationships at every opportunity is most important to ensuring the best chance at developing good infant mental health (DCYA, 2013).

Hayes and Watson (2013) indicate that when a parent develops a positive perception of their child's disability, this can assist in the reduction of stress. Pakenham et al., (2004) noted that when a parent has a greater understanding of a child's difficulty, from the child's point of view this leads to improvements in the parent child relationship. Additionally, Watchtel and Carter (2008) indicate that a mother's increased understanding of her child's diagnosis can lead to an enhanced mother child relationship with an amplified mutual

reciprocity. Services that are successful at improving parent-child relationships may produce significantly more positive outcomes than those that focus purely on child developmental goals (C4EO, 2010).

There is strong evidence that parental behaviours are modifiable when provided with high quality parental input. This is particularly evident for parents of children with an identified behavioural need. There is consistent evidence that parenting behaviour is associated with positive child development, improved social and emotional wellbeing. C4EO (2010) report that parents value a service that meets the needs of the whole family. Information on outcomes valued most by families tend to be peer related and in natural contexts.

Family centred practices are noted to produce positive effects for families directly. However family centred practices have been shown to produce positive effects on child development indirectly (Moore, 2012). Dunst et al. (2009) argue that child focused or parent/child focused interventions are what are done, family centred practices are how interventions are implemented. Family centred practice is expected to influence the way in which interventions are carried out.

## **1.8 Integrated Services and Supports**

The integration of services leads to consistency and accountability in decisions and actions. It also ensures that resources are protected and duplications deleted. A fully integrated system results in better outcomes for patients (HSE, 2014, ARACY, 2015). Children develop across a number of domains and access a variety of environments. In the case of a child with additional needs they may require the support of various professionals across these domains (Bruder, 2010). In order to ensure that children and family outcomes are optimised it is essential that a level of interagency integration and cross sectoral working occurs (ARACY, 2015). Evidence suggests that there is a need to ensure the services delivered across the domains of a child's environment are integrated and premised upon a team approach with the needs of the child and family remaining central. Early childhood interventions are reported to work best when collaboration occurs between universal and

tertiary services to facilitate early identification, early referral and secondary consultation to a broad range of children's and family services promoting participation and positive outcomes (ACT, 2015).

The Centre for Effective Services in Ireland (Boydell, 2015) discusses integrated service provision for children's services, indicating that integration of services is described as occurring at many levels, including interagency governance, integrated strategy, integrated processes and integrated frontline delivery. How effective integration and collaboration is at these levels has an impact on outcomes for children and families.

## **1.9 Integrated Systems and Interagency Team Working**

Interagency working has become increasingly prevalent in children's services internationally. Many jurisdictions such as the UK and the USA promote the seamless collaboration of services providing support to children and families. Better Outcomes, Brighter Future; the National Policy Framework for Children and Young People 2014-2020 (DCYA, 2014), underlines the Irish Government's commitment to cross government and interagency collaboration and coordination. The framework calls on government departments to work across traditional boundaries and connect infrastructure within organisations and systems, aimed at achieving better outcomes for all children and families.

Interagency working is purported to advance consistency and accountability in decisions and actions (Boydell, 2015). It also ensures that resources are protected and duplications deleted. There is emerging evidence that systems working in an integrated manner can result in improved outcomes for children and families (Stantham, 2011). The HSE Corporate Plan 2016 advocates integrated care as a means of improving patient outcomes. Promising evidence from many countries indicates that developing links between services can result in improved professional practices and the provision of enhanced support at an earlier stage for families and children. Thereby, resulting in better access for children and families to the appropriate levels of support required for them. However research also indicates that many barriers exist to cohesive interagency working. Stantham (2011) notes that culture,

professional beliefs, systems and difficulties with information sharing are among issues that can impede interagency working. Factors that facilitate interagency working include clarity of roles, coherent long term vision, commitment to joint working at all levels of the organisation, the development of robust interpersonal relationships between partners and strong leadership. The systems required to facilitate interagency working require time to become embedded within practice.

Research indicates that interagency working is not inherently positive. In order for this practice to deliver the perceived benefits, interagency working must be implemented well and should be of the highest quality possible (Stantham, 2011; Boydell, 2015).

Stantham (2011) defines interagency working as more than one agency working together in a planned and formal manner. Frost (2005) describes four levels of interagency working. The levels range from cooperative behaviours progressing towards integration. That is cooperation, collaboration, coordination and integration. The key features of these definitions include joint working between services/agencies with the sole purpose of increasing public value and creating aligned processes (Boydell, 2015).

The C4EO (2010) note that early service provision for children should include healthcare, educational and therapeutic support. The organisation calls for greater coordination of multiagency support and partnership across agencies and geographical boundaries. In Scotland the Getting it Right For Every Child (2009) initiative advocates greater consistency across services, avoidance of silos and a single point of access to services, ranging from universal towards targeted supports utilising the concept of progressive universalism. This is echoed in the NHS leadership framework (2013) and the HSE plan for integrated care as per the integrated care programmes.

#### **FACTORS PROMOTING QUALITY INTERAGENCY WORKING**

- Role clarification
- Coherent long term vision
- Commitment to joint working at all levels of the organisation
- Robust relationships between partners
- Strong Strategic leadership at all levels of the organisation

#### **BARRIERS TO COHESIVE INTERAGENCY WORKING**

- Culture
- Professional beliefs
- Incompatible systems
- Difficulty sharing information

### **1.10 Team Working**

Children with disabilities are reported to have contact with 10 professionals and approximate 20 visits per year, on average. The provision of services by multiple agencies and several professionals who may be governed by differing policies, processes and procedures may be daunting for some families (ACT, 2015). Researchers suggest that early childhood intervention services should be delivered following an integrated team approach (Bruder, 2010). Team work can be represented on a continuum ranging from multidisciplinary teamwork through to an interdisciplinary framework towards trans-disciplinary teamwork and the utilisation of a key worker model. In Ireland the most common forms of teamwork service provision in the disability sector are multidisciplinary working with some interdisciplinary service provision (Fitzgerald et al., 2015). However, on full establishment of children's disability network teams nationally under the national PDS programme, interdisciplinary working will be a key cornerstone of this child and family centred model of service. Interdisciplinary working involves a number of professionals that may work independently with families to conduct individual assessments and develop goals. The team of professionals meet regularly to complete service planning activities related to the child (ACT, 2014).

Fitzgerald et al. (2015) report that the core principle of multidisciplinary and trans-disciplinary working differs. That is, the multidisciplinary approach is child focused, where the trans-disciplinary approach is family focused. Bruder (2010) indicates that a family focus is an appropriate approach during the early years. Secondary to the family unit's constancy in a child's life and the primary unit for family centred service delivery.

### ***Key Messages for Integrated Services***

- *Interagency working is purported to advance consistency and accountability in decisions and actions*
- *There is emerging evidence indicates that developing links between services improves professional practices, enhance support for families at an earlier stage*
- *Interagency working is not inherently positive. It must be implemented well*
- *Interagency working requires time and leadership to embed practices and align cultures*

### ***Team Working***

- *Key workers – when provided with sufficient training, supervision role clarification, dedicated time and resources can impact positively on family outcomes*

## **1.11 Key Workers**

ACT (2014) advocates the use of a key worker model within early intervention services and indicates that this model is an example of best practice. The key worker's role is to work in partnership with both families and the team providing services to build capacity to support the child's development. The primary task of a key worker is to build a supportive relationship with the family , focusing on the child within the context of the family and community (ACT, 2014) A key worker has been identified as a most valuable resource in supporting families navigates often fragmented systems and ensuring the timeliest access to services (ARACY, 2015).

A C4EO report 2010 indicates that families of children with complex needs value services providing a single point of contact and family centred practices. This report also notes that regular contact with services and supportive parent – professional relationships are considered significantly important to families. In services where a key worker/key point of contact had been appointed families reported better access, greater empowerment and reduced levels of stress. Sloper et al. (2006) note that in services where a key worker was provided with appropriate training, supervision and peer support, role clarification and dedicated time, the outcomes for children and families was better. This implies that for key workers to complete their roles well, access to dedicated supervision, role clarification, protected time and resources are required to ensure better outcomes for families.

### **1.12 Evidence Based Practice**

Successful interventions are guided by a theoretical model that specifies the relationship between goals and the methods employed to achieve them (Shonkoff, Philips, 2000). Evidence based practice within the field of early intervention has been defined by Buysse and Wesley (2006) as a *“decision making process that integrates the best available research evidence with family and professional wisdom and values”*. This definition underlines the importance of clinical intuition along with consideration of family as partners in decision making with reference to scientific proof. Moore (2010) indicates that this definition of evidence based practice in early intervention indicates that clinicians cannot simply depend on research based ‘proven’ practices. Clinicians must also take into account clinical knowledge and family values.

Buysse and Wesley (2006) recommend a five–step process for evidence based practice decision making in early intervention for practitioners:

1. *Pose the question*
2. *Find the best available research evidence*
3. *Appraise the evidence quality and relevance*
4. *Integrate research and values with wisdom*
5. *Evaluate*

Moore (2012) argues that Buysse and Wesley's model needs to be expanded to consider basing decisions on outcomes. Moore (2012) proposes a six-step model for evidence informed decision making:

1. *Decide the outcome with the family*
2. *Identify how the outcome will be achieved*
3. *Identify the most effective known strategy for achieving the outcome:*
  - a. *Review efficacy studies to establish what has been tested and shown to be effective*
  - b. *Where there are gaps in the evidence, review practice-based evidence*
  - c. *Review what is known about how particular interventions work*
4. *Select strategies with the best evidence*
5. *Consult with family to identify which strategy can be most appropriately implemented with regard to their particular situation*
6. *Support family with implementation and monitor outcome*

### **1.13 Effective Intervention Strategies**

Developing effective intervention strategies is an initial step in improving outcomes for children and families. This must be followed by clinicians knowing and using the strategies in a manner that adheres to the fidelity of the particular strategy. Moore (2012) reports that for interventions to be successful, both the intervention strategy and the implementation process must be effective. Several studies indicate that higher levels of fidelity correlate to positive program outcomes (Moore, 2012).

The intensity of service provision is another aspect of evidence based interventions. Moore (2012) concludes that there is very little research that compares different levels of intensity. Stantham (2010) argues that intervention should match the level of need experienced by families and children. Moore (2012) reports that intensive programs may be more appropriate for parents experiencing severe difficulties while shorter lower level programs will be more appropriate for parents experiencing less serious problems.

Measuring thresholds for interventions and appropriate service responses for need has been an area of early intervention services that has not received significant research (ARACY, 2015). Limited resources and work pressures have been identified as causes for the escalation of intervention thresholds (Platt & Turnkey, 2011). High thresholds for services may mean that families with the most significant need have difficulty accessing the services required (Fox et al., 2015). Fox (2015) identifies this as a gate keeping process and notes that it likely reflects the complexities and demands of an overburdened system. Yet gate keeping of services in this manner is noted to be contrary to the objective of building an integrated network of support around a child and family.

Systems and organisational factors influence the explicit and implicit assumptions regarding interventions thresholds. Intervention thresholds are impacted by the level of demand from services, time constraints and service processes and procedures (Fox et al., 2015).

### ***Key Messages for Evidenced Based Practices in Early Intervention***

- Clinicians must combine research ‘proven’ practices with clinical knowledge and family values

### ***Implementing effective intervention strategies***

- Strategies that are implemented with high levels of fidelity correlate to positive outcomes
- Intensive programs may be more appropriate for parents experiencing severe difficulties, while shorter programs may be more appropriate for parents experiencing less severe difficulties
- High thresholds for accessing health services may mean that the most needy have difficulty accessing services required

### ***How evidence based interventions are implemented***

- Services that are relationship based yield the most promising returns.
- There is strong evidence that the relationship between the clinician and the client determines the effectiveness of the intervention. This is the case even when the relationship is not the focus of the intervention
- It is not sufficient to provide good relational support to parents. Parents must also be provided with strategies and skills that have a direct impact on their child’s function and participation

## 1.14 The importance of relationships in the delivery of early intervention strategies

Research indicates that although it is necessary to implement effective evidence based interventions it is equally as important to consider how these interventions will be delivered. Moore (2012) reports that services that are relationship based yield the most promising returns and identifies strong evidence that the relationship between the practitioner and client determines the effectiveness of the intervention, regardless of evidence for the particular intervention being delivered. Kalmanson and Seligman (1992) indicate the success of interventions rests on the quality of the provider-client relationship. This is the case even when the relationship is not the focus of the intervention. Conversely, Moore (2012) also notes that, although the quality of the relationship between parents and professionals has been identified as a key constituent to the success of an intervention, parents also require instruction in the skills and strategies that have a direct impact on their child's functioning and participation.

Moore (2012) suggests that:

*There appears to be a number of primary threshold factors associated with enhanced early intervention outcomes. These include: **shared decision making** between parent and professional; **non-stigmatising** presentation of intervention; **cultural awareness** and sensitivity; **flexible setting/hours**; and **provision of crisis help** prior to other intervention aims.*

## 1.15 Effective Practices in Early intervention Services

Many of the abundant effective early intervention strategies apply to children with a range of needs while some are specific to disabilities (Moore, 2012). A significant body of research exists regarding interventions that may be applied to particular populations of children and discipline specific research. However, the C4EO (2010) reports that there is a shortage of studies comparing one intervention type with another. Moreover there is an inadequate amount of research that differentiates between different intervention with different impairment types or other differentiated groups. C4EO (2009) indicate that some studies have shown returns for children from specific programmes over another, although the gains are minimal, other studies have found that gains are mostly equivalent.

C4EO (2010) review of *'which early years interventions are most effective for particular groups of disabled children'* found that the important difference in a successful approach may derive from one or more of the following elements: technique, teaching style, environment or resource level. C4EO (2010) assert that no single intervention for **Autism Spectrum Disorders (ASD)** has consistent advantages over others. Wong et al. (2015) completed a full analysis of evidence base interventions for children with ASD. They conclude that while there is an expansion of the number of evidenced base practices utilised with children diagnosed with ASD translating these practices from theory into practice will require professional development and support for implementing the practices with fidelity. C4EO (2010) also identify that the introduction of key worker services is associated with better family relationships with services, quicker access to benefits and reduced parental stress.

Each strategy and its implementation with a particular cohort of children, along with the discipline implementing it, is beyond the scope of this research. However general strategies that impact on a child's social experiences and are often employed within the early intervention setting are noted below. The strategies outlined below are based on a care giver mediated approach to early intervention as described by Dunst & Trivette (2009) cited in Moore et al. (2011).

## **1.16 Strategies known to be Effective for Interactions with Children**

- ***Response – contingent child learning:***

Research indicates that children with disabilities are capable of response contingent learning. Dunst (2007) indicates that this learning strategy is useful in early intervention. Children with disabilities may take longer to learn the relationship between consequences and their behaviour.

- ***Participatory child learning opportunities:***

Dunst et al. (2011) report that there are many factors that impact on a child's learning. However, a child's active engagement in tasks has been identified as a significant contributory factor in a child's learning and development. Research indicates that when a

child comes to understand their contribution to environmental consequences, this leads to a sense of mastery.

- ***Interest Based Child learning:***

Moore (2012) reports experiences and opportunities that are based on a child's individual interests are more likely to engage children in prolonged interactions with people and objects. This promotes practicing existing skills and learning new behaviours. Recent research indicates that children who participated in interest based learning activities demonstrated more positive social emotional behaviours and made developmental progress when compared to children who did not engage in interest based learning activities.

- ***Parent responsiveness to child behaviour:***

Moore (2012) indicates parental responsiveness during child-parent interactions is a primary determinate of child development. Parental responsiveness includes parental response quality, timing, appropriateness, affect and comforting. Studies indicate that parents' behaviour is maximised when a parent is attuned to a child's signals and intent to communicate and responds appropriately to a child's behaviour. Parent- child interactions can then become mutually reinforcing.

- ***Everyday learning opportunities and the use of natural learning environments:***

Research indicates learning opportunities that provide a context for interest expression or interest – evoking features are associated with increased child functioning. Furthermore benefits increased when learning occurs in everyday activities.

Dunst, Bruder (2002) suggest that the traditional clinic based approach to early intervention may limit a child's opportunity to practice the skills required for development. Moreover these authors assert that it may be difficult to generalise the skills learnt in a clinical setting into real world experiences.

Children's behaviour changes through direct experiences provided by their social and physical environments. In terms of social experiences using the strategies that are outlined above promotes children's learning and development (Moore, 2012).

## 1.17 Conclusion

The overarching aim of early intervention services is to enhance a child's meaningful participation in their natural environments. Early intervention has been identified as a key determinant of positive life outcomes for children with disabilities. Research indicates that children are shaped by their environments. This includes all the social relationships and experiences that shape a child's reality. That being the case, early intervention services have the opportunity to collaborate with parents and early education specialists to create natural contexts and environments that are fully supportive of a child's learning and development. The introduction of strategies that strengthen relationships between a child and their caregiver, the caregiver and professionals involved in the child's care and the relationships between various agencies charged with supporting the child's development will serve to enhance and strengthen children's meaningful participation.

Evidence indicates that there is not one single model of delivery for early intervention services. Emerging research suggests that a service model must be based upon

- *development of a set of values and principles to serve as a foundation for systems and services*
- *a strong emphasis on individualised and family-driven care*
- *service responses designed to meet the needs of children and their families rather than requirements of funders, systems, and providers*
- *a strong focus on culturally competent systems and services;*
- *a balance between the focus on deficits and a focus on strengths (Friedman, 2006)*

Fox et al. (2015) note there are strong indications that the 'ideal system' is not a rigid model. Alternatively cultures, structures and processes need to be flexible and responsive, underpinned by robust accountability and governance mechanisms, to enable adaptation and problem solving.

## SECTION 2

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# RESULTS OF HEALTH SUPPORTS SURVEY

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## 2.1 INTRODUCTION

Section 2 provides an analysis of the health supports survey completed by subgroup 4.

A health supports survey (see Appendix 1 Health Supports Survey: Supporting Access to Early Childhood Care and education (ECCE) Programme for Children with a Disability), requesting information from healthcare service providers regarding universal and targeted supports provided to preschool providers in the previous eighteen months, was disseminated to all CHOs via the CHO representatives of AIM Level 6 Health Service Supports Working Group. Additionally information and support was provided to PDS local implementation groups (LIGs) for their completion of the survey and further dissemination to service leads as required. In areas where re-configuration had not taken place, Heads of Service were asked to complete the survey for their own discipline.

Initial response rate was slow. As a result the deadline for survey completion was extended. All responses were mapped according to 9 HSE Community Health Organisations (CHO). Information on agencies operating in each CHO and LIG area was Cross referenced in an effort to ensure representation from all stakeholders within health. A gap analysis was completed. This provided information on areas where no response had been returned. Researchers identified and contacted relevant disability managers and heads of service and noted their responses. Overall, information was returned from each LIG but not from each discipline within each LIG. Although every effort was made within the timeframe available to capture information from every service, a number of gaps in survey returns may exist.

Respondents included service managers and clinicians from both reconfigured and pre-reconfigured areas. In some areas responses were received from Heads of Service in primary care. Of the 85 responses received 15.29 % were received from primary care, 75.27% were received from Early Intervention Team's including voluntary agencies pre and post reconfiguration into children's network disability teams. 9.4% were classified into an "other" category. This included unidentified responses, responses that did not fall into either primary care or social care and those that identified themselves as falling into both.

The information was collated and calculated as a percentage of responses. Percentage responses per LIG reflect the number of respondents from that LIG and not necessarily the

distribution of services. For example in one area a single service is responsible for providing disability services to children in early services. However three responses were returned from this area and although one of the responses was provided through a business unit this response could not be discounted and falls into the other category. In an effort to determine the gaps within disability services only further analysis was conducted on responses classified as Early Intervention Teams, including voluntary agencies pre and post reconfiguration. This provides an opportunity to examine service provision within the social care remit. Thus ensuring that LIGs have the opportunity to reinforce good practice and expand engagement with local preschool providers as appropriate.

## 2.2 Survey Results

Results indicate:

- All CHO and LIG areas are providing some elements of identified universal supports to preschool providers
- All CHO and LIG areas are providing individualised targeted supports to children with disabilities attending mainstream preschools
- All CHO and LIG areas are providing some training to preschools. Specific training such as Lámh and HANEN appear to be provided on a wider basis nationally than other training models identified such as training on the Developmental Individual Differences and Relationship model (DIR).
- That there is diverse provision of supports across the country
- There is evidence of good practice models supporting children with disabilities across the country
- There is evidence of collaboration with preschools in all CHO's nationally.

(See Appendix 3: Mapping of Current Services Provision to Preschools)

## 2.3 Universal Strategies

Respondents were asked to identify what supports, both universal and targeted, their service provides to children with additional health needs, attending preschool (ECCE Programme).

Universal interventions: are offered to all individuals and are generally preventative in nature (ARACY, 2015). Universal strategies explored in this service relate to access to information. This includes general information regarding service provision and navigation moving towards more specific targeted information on universal areas of development and challenge likely to be experienced by children attending preschool.

- General Information Leaflets
- Open Evening
- Once off talks
- Practical Strategies

Providing access to information appears to be a strong theme for health care services. HIQUA's Safer Better Healthcare Standards (2013) reinforce this as an aspect of patient centred care. In addition research has identified that access to information regarding a service is a core component of family centred practice.

While some services surveyed do not provide general information leaflets a large majority provide more specific information on relevant topics. This may highlight health services' responsiveness towards local needs and the profile of children attending mainstream preschool who attend these services.

## 2.4 Targeted Supports

Targeted interventions can be defined as: interventions catering for individuals experiencing specific or multiple issues (ARACY, 2015). The targeted supports considered for the purposes of this survey include items where an individual child's strengths are

developed and their needs are identified and supported through collaboration and information sharing with individuals within their natural setting.

- Preschool Readiness
- Preschool visits (prior to and following admission)
- Health providers involvement with IEP
- Telephone Support to preschool provider
- Invitation to preschool providers to attend therapy sessions
- Preschool Programme
- Preschool Visit on request
- Provision of Specialised equipment

The results indicate that a significant proportion of health services provide some form of individualised targeted support to children with disabilities within mainstream preschool. Evidence suggests that parents value family centred services delivered by reliable professionals who have the skills and knowledge relevant to the child's impairment (c4EO, 2009).

## **2.5 Provision of Family Centred Practice based services in Ireland**

Children must be supported within their natural environments through the context of their family system. Policy advocates supporting children in a holistic manner with special consideration being given to strengthening parental capacity. Parents of children with disability have particular needs and require consolidated supports to ensure that their children receive every opportunity to achieve meaningful participation. Family centred practice is at the foundation of Irish disability services. This is also true for early education and care whereby the impact of the child's home environment on a child's development is fully acknowledged (ARACY, 2015). While disability services can and do collaborate with early education as a natural context for the child with disability, health services role in supporting the family system around the child cannot be negated. It is therefore necessary

to support the links between family/home, school and clinical services with the child's needs remaining at the centre.

The evidence from this study suggests the Irish disability services engage in practices that are family centred and meet the individual needs of the child. Examples provided in the survey include:

A Cork service indicated:

*"OT provides individualized programs and information sessions to preschools and parents".*

A service in the south east reports:

*"Interdisciplinary support is offered to the child and family at planning stage and then on-going support to facilitate the placement e.g. adaptation of environment, purchasing of equipment, identifying support needs and advice and support around participation in the programme".*

A clinician based in Dublin reports:

*"Most of the children on our caseload could not attend preschool at all without the placement being supported by Clinical Psychology. Parents, children and preschool staff are offered support in preparing for the placement, responding to specific difficulties as they arise and later in the process, liaison to ensure a smooth transition onto national school. This support involves increasing preschool staff's understanding of the difficulties and disabilities experienced by the children, and specific training in methods to help these children. We focus together (Clinical Psychologist, Parents and Preschool Staff) upon helping the children to feel less distressed, to develop their independence skills, to play and learn more productively and to integrate with their peers socially as much as possible, all with a view to gradually preparing them for their primary school placement".*

Although the research conducted for this report did not formally request information on family centred practices, information provided through qualitative questions and on targeted supports provided to children attending preschool indicates that services in Ireland actively engage in family centred practices. Dunst (2010) reports that if family centred practices are to remain at the heart of service delivery this requires constant monitoring and evaluation. The survey indicates 96% of services within LIGs who responded provide

preschool readiness input. 91% of services within LIGs who responded have services offering an invitation to preschool for attendance to therapy sessions as appropriate.

With the implementation of an outcomes-focused performance management and accountability framework for disability teams in 2016 family centred practices such as Individual Family Services plans will be reinforced.

## **2.6 Collaboration and Integration in Irish Services for Children with a Disability**

In the *Getting it Right from the Start* Report (DCYA 2013), an expert group recommend the direction for the next National Early Years Strategy and includes that all individuals working with children collaborate and communicate with each other and with children and families in an atmosphere of mutual respect and common purpose.

An Education Health Working Group developed a *Framework for Collaborative Working between Education and Health* (2013) which recommends a National Cross Sectoral Steering Group to advice and support local Health Education fora to share information, communication, build relationships, transitions support and planning, and to network. A *Report on an Outcomes-Focused Performance Management and Accountability Framework for Early Intervention and School Age Disability Network Teams* (2013) advocates that children should have the opportunity to access an integrated service model in their local community.

Partnership, communication and collaboration are concepts underlying many social policies both nationally and internationally. It is underpinned by the concepts of shared knowledge and the most efficient utilisation of resources. Integrated services have also been found to yield better outcomes for children and their families.

Early Education and Care in Ireland is governed through the Department of Children and Youth Affairs. The provision of disability services for children in Ireland is governed ultimately by the department of health through the HSE and its agencies. Many policy

documents exist advocating the integration and linking and communication of services. Not least the report “Getting it Right from the Start” (2013) recommending a National Early Years Strategy Policy. However until now there have been no mandated shared working arrangements between early education and the health sector. AIM will support integration and collaboration at all 7 levels of the programme highlighting the vision that all children regardless of their developmental needs will have access to early education. AIM is interlinked and collaborative in nature for all 7 levels. Level 4 Early Years Specialists have a role in supporting the child in preschool and seeking additional assistance from health services when critical to that child’s optimal participation in the preschool setting. Level 6 health service supports have a role in supporting preschool providers to understand the child’s developmental profile and provide information on how best to enhance the child’s participation and developmental trajectory in preschool. In addition the impact of the child’s parents and family context cannot be underestimated. The World Health Organisation advocates considering *the* child in a holistic manner and avoiding compartmentalisation. The complex nature of the system both around the child and within services is highlighted and underlines the requirement for an integrated system protecting resources and achieving the best outcomes for children and families.

Research undertaken for this report indicates that there are many examples of collaboration and communication between preschool providers and clinical services nationally. These links have grown organically and serve to support children known to health services participate in this aspect of their life role. It appears that in alignment with ARACY’S (2015) recommendations as above, local services in Ireland have developed structures and processes to align and initiate joint working.

The services; CNDTs (Children’s Network Disability Teams, EITs (Early Intervention Teams) and PCT (Primary Care Teams) are allocated to LIG (Local Implementation Group) areas. Examples provided in the survey include:

A service in Dublin reports:

*"We have an outreach program where an outreach key worker supports the child, family and preschool provider to a successful transition from home to an integrated preschool placement. It is a full team approach to transfer all programs & guidance to the preschool generally delivered by Outreach key worker/Home teacher (referred to above as Child and family support worker). Often this is also supported by individual members of the team based on the child's individual needs. Preschool staff would be invited to participate in a child's individual planning meetings but not therapy sessions. In the absence of a managerial dropdown post we wish to highlight their full & very active involvement in all of the above".*

A service in the west of Ireland indicates that:

*"All children in Early Intervention Services xxxxxx received ongoing support in the preschool from the relevant disciplines involved. Our model of service is to work in partnership with the preschools to enable them to best support the child throughout the day. Preschool programmes are part and parcel of this. Some children who require additional support in order to access the curriculum, interact with their peers, or need support for management of behaviour/medical/physical needs can be supported through a grant provided to individual preschools, "Welcome to Preschool xxxxxxxx". This grant, which is managed by the Brothers of Charity Services xxxxxxxx, enables the preschools to employ a support worker for a number of hours each week or to back fill a member of their current staff who may be assigned to provide one to one support for the child. In addition to the grant a member of staff, Mentor, from the xxxxxxxx Brothers of Charity Preschool Resource Supports works with the preschool to provide advice and support".*

A service in the north of the country reports:

*"The team would predominantly provide support to pre-schools where children known to the service are attending. We have developed a disability inclusion booklet as well as a pre-writing pack for pre-schools which have gradually been distributed to most pre-schools in the area. We have provided training to pre-school staff in the area of disability awareness, pre-writing skills, sensory workshops, PECS and Lámh - this is provided in our centre and pre-school staff have been invited to attend training days. Visits prior to a child starting a pre-school would be predominantly in ASD preschools (SLT & OT) or where there are equipment needs (OT & PT). Preparation for starting pre-school would be covered in intervention sessions, more focused on those children with ASD i.e. start/finish boxes; visual schedules, social stories etc. Postural management training or manual handling would only be provided in the context of a child's specific equipment needs, not as general training. We do share our PCP goals for children and provide written programmes, with the onus on pre-schools to*

*contact us if any queries or concerns. There is a huge demand from pre-schools (especially ASD pre-schools) for support.”*

Additionally, 91% of Local Implementation Groups report that they provide practical strategies workshops. These workshops cover topics of relevance to the children attending services and the preschool providers. It is not clear however if all preschool providers are invited to attend these workshops or if it is only preschool providers who support children named within the service are invited to attend.

100% of LIGs report that services in their area provide preschool visits when required. This is further evidence that collaboration and communication is occurring between these two sectors nationally. This again appears to be needs led and child specific.

What is clear from the research is that collaboration and communication from clinical services are offered to preschools when required to support children attending disability services.

Suter et al. (2009), report that a fully integrated system includes 10 key elements. These include centralised planning, patient centeredness, standardised protocols, efficient methods of communication, team role clarity, methods to measure care processes, effective leadership to bridge cultural diversity and governance structures. Until now there has been no interdepartmental national strategy for children’s services. AIM will serve as the platform for interdepartmental collaboration. This model will provide greater governance and accountability for all children’s services. Moreover it will direct services towards outcomes and ensure continuous quality improvement in line with international standards. Interagency collaboration is occurring to support the alignment of processes for Early Years Specialists, preschool providers and clinical services. This requires an atmosphere of mutual respect, collaboration and communication, both at national and local levels. The HSE Joint Working Protocols document (2016) for disability teams within the HSE is an example of this collaboration at national level. The impact of this document will require vigorous monitoring and evaluation along with robust feedback from local services. The results of this will inform

another cycle of communication and collaboration at national level and move services towards integration for the benefit of the children and families that are served by our services. Training of preschools by health service staff will in the short term strengthen links between the two sectors. It will provide an opportunity for professionals to work together, share skills and knowledge leading to a common purpose as underpinned in the vision for the programme and develop greater understanding of needs and processes.

Collaboration between early years educators and early intervention teams will lead to inclusive practices ensuring that all professionals are equipped to support all children regardless of their backgrounds (ACT, 2014).

## 2.7 Training

There are a number of evidence based training programmes that can be provided to early educators from health services. In order to ascertain the prevalence of this training a section regarding training programmes was included into the survey. A number of training programmes that are typically provided to early educators were identified and noted within the survey. Respondents were informed that the list provided was not exhaustive and any other training that was carried out could be identified in another question. No respondents expanded on the list provided. The list of training courses provided is as follows:

<b>Training identified in survey</b>	
Hanen	Manual Handling
Early Bird Plus	Postural management
DIR Floortime	Lámh
Sensory Integration	

Results indicate that while training is occurring within each LIG there is a wide variety regarding topics provided. One respondent replied *'At present, we are not in a position to work directly with preschools in terms of training. Parents are welcome to invite preschool staff along to therapy sessions as appropriate. We can offer advice over the telephone and send preschool programs on request.'* (CHO 9 respondent).

Evidence suggests that when early educators are guided and supported through careful and well-planned training courses, it can be anticipated that their beliefs will change. This results in remarkable improvements in their practices. Survey results indicate many health services identified early communication strategies and systems as being the most widely provided training programmes to preschools. It is likely that this is a reflection on the stage of development for many pre-schoolers and the central role communication plays regarding social interactions and behaviours.

In addition many health services within LIG areas provide support regarding postural management. This may also reflect the necessity of good postural stability for supporting a child to participate and engage with their environment.

Results of a survey completed by County Childcare Committees (2016) indicate that early educators welcome training from healthcare providers. In addition, many requested training on behaviour management, integrating children with disabilities, disability awareness training, and training for complex medical needs, among others.

## **2.8 Conclusion**

Evidence suggests that an integrated system based on family centred outcomes and child centred practices yields the most positive results for children accessing health and early education services. This survey has captured evidence of good practice and collaboration between health services and early education. An example of this was provided by a CHO 1 respondent:

*'The team would predominantly provide support to pre-schools where children known to the service are attending. We have developed a disability inclusion booklet as well as a pre-writing pack for preschools which have gradually been distributed to most pre-schools in the area. We have provided training to pre-school staff in the*

*area of disability awareness, pre-writing skills, sensory workshops, PECS and Lámh - this is provided in our centre and pre-school staff have been invited to attend training days. Visits prior to a child starting a pre-school would be predominantly in ASD preschools (SLT & OT) or where there are equipment needs (OT & PT). Preparation for starting pre-school would be covered in intervention sessions, more focused on those children with ASD i.e. start/finish boxes; visual schedules, social stories etc. Postural management training or manual handling would only be provided in the context of a child's specific equipment needs, not as general training. We do share our PCP goals for children and provide written programmes, with the onus on pre-schools to contact us if any queries or concerns. There is a huge demand from pre-schools (especially ASD pre-schools) for support.'*

Health services in Ireland are undergoing an unprecedented transformation. For the most part health professionals on Children's Disability Network Teams work with an identified child following a referral to the children's network disability team. During this period of intervention clinicians examine many areas of a child's life in an effort to maximise their potential and ensure meaningful participation within relevant environments. This often leads to the provision of education for the child's care givers regarding a child's strengths and areas of difficulty. In addition specific individualised supports and programs may be provided to enhance participation. The results of this survey reflect this. For the most part health care professionals are providing programs and supports for children on a waiting list or accessing services (i.e. "known" children). One aspect of the "known" child's life is their preschool environment. It appears that, it is within this context that health service supports for preschool providers have been available, in varying forms and levels. This health service survey results identify targeted supports as those which are most prolific nationally.

A respondent from CHO 2 noted that *"All children in Early Intervention Services received ongoing support in the preschool from the relevant disciplines involved. Our model of service is to work in partnership with preschools to enable them to best support the child throughout the day. Preschool programmes are part and parcel of this"*. Another respondent from CHO 2 informed that *"all children (attached to the team) are offered the chance to attend local preschools"*. A respondent from CHO 6 reports providing *"support to individual children in preschool when required"*

Universal supports as identified for the purpose of this survey relate primarily to access for information. This is information for children's caregivers in terms of accessing services and information in terms of education regarding specific topics relevant to all preschool children. The survey reveals that all CHO's offer some access to information. Many LIGS provide talks and practical strategy workshops. However there appears to be a lack of coordination and consistency regarding the information that is available to all relevant stakeholders. The standardisation of information available to families and mainstream preschool providers maybe a platform from which integrated, outcome based practice can develop and continue to expand.

Section 3 of this report explores the evidence base for health supports identified within the survey results. It benchmarks health supports against the components of a successful early intervention service/suite of models. The evidence base for each support is discussed along with charts illustrating information regarding the prevalence of the particular health support in each LIG area as per survey result.

## **SECTION 3**

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# **HEALTH SERVICE SUPPORTS**

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### 3.1 Introduction

Section 3 of this report explores the evidence base for the health supports/strategies identified within the survey. It benchmarks health supports/strategies against the components of a successful early intervention service/suite of models. The evidence base for each health support/strategy is discussed along with information illustrating the prevalence each specific health support/strategy in each Local implementation Group (LIG) area as per survey result.

#### **Core Components of Early Services Associated with Positive Outcomes for Children and Families**

- Family Centred Practice
  - Natural context
  - Key Stage transitions
  - Access to Information
  - Key Point of contact
- Outcomes based
- Interagency collaboration
- Evidence based
- Systems based on guiding principles and values
- Governance and accountability

## 3.2 Family Centred Practices

***“A set of values, skills, behaviours and knowledge that recognises the centrality of families in the lives of children and young people”***

(State Government of Victoria, 2011)

Although information on family centred practice was not explicitly sought through the survey examples of family centred practice are embedded within service provision in Ireland and as such implicit information was extrapolated.

Examples of Family Centred Practice examined in this report include:

- Transition planning
- IEP
- Individual programs
- Phone support for schools
- Visits on request
- Access to information
- Leaflets
- Open evenings
- Practical talks

### Useful Websites

The Victoria government provides practical guides on the implementation of family centred practice these can be found at [www.dhs.vic.gov.au](http://www.dhs.vic.gov.au) family centred practice

*Dunst and Trivette’s family centred checklist (2003)*

### ***KEY MESSAGE***

- *Ensure family centred practice is embedded in services guiding principles*
- *Adherence to family centred practices requires vigilant monitoring*

### 3.3 Information Leaflets

Information leaflets have been identified as a useful means for conveying information. Information leaflets with regard to children's disability services typically provide information on the location of a service, the individuals involved in the service, access to the service and intervention/support provided. Additionally many information leaflets exist to provide information on particular conditions.

Nicholl et al. (2014) note that consultation around the content to be included in an information leaflet ensures a broad range of views. Information leaflets may be provided to supplement advice from professionals and are often expected as part of treatment (McClinchy et al., 2011). Verbal explanation may not always be sufficient e.g. a detail process or procedure, and written information should be provided in the form of a leaflet to accompany the verbal information (Saiklang & Skirton, 2015). Additionally it must be noted that information provided in leaflet format must be accessible to all-this may require professional support from an agency such as the National Adult Literacy Agency (NALA).

#### ***Key messages –Information Leaflets***

- Contain information about a particular topic
- Means of sharing information
- Needs to be accurate
- Can be a supplement to verbal information given

This Health Service Supports Survey indicates ....

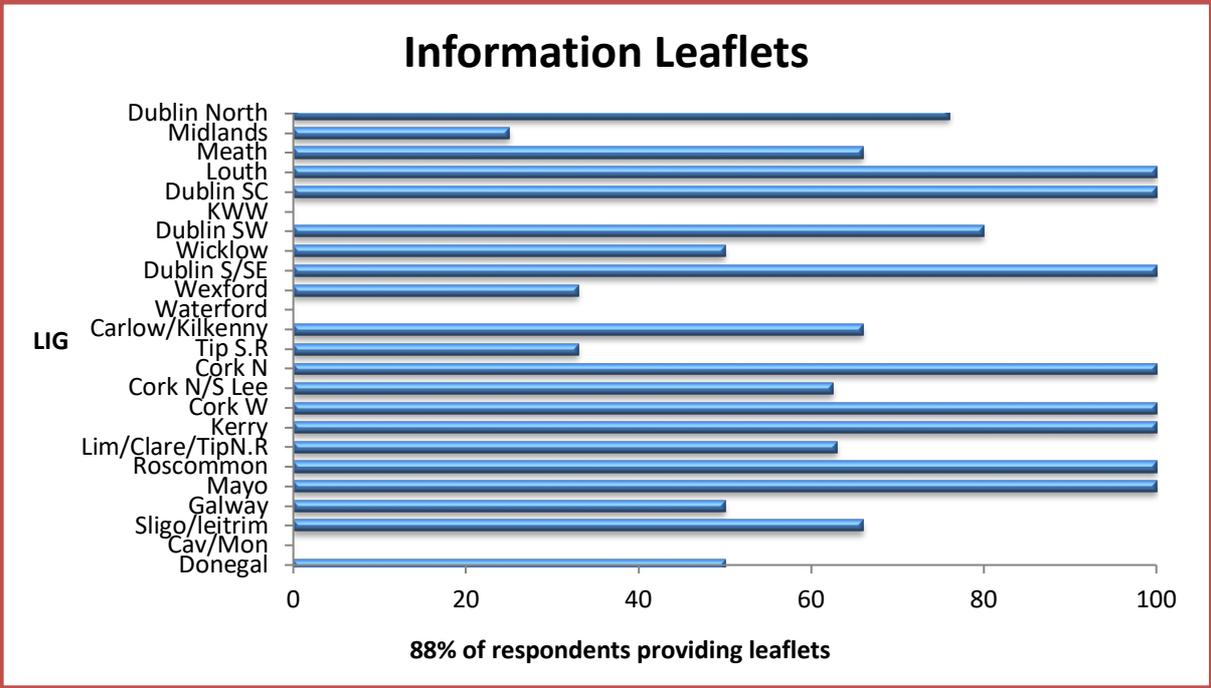


Examples of how leaflets are used in Disability Services:

- ❖ Sharing information about services e.g. profile on the service provider, pathways of service, role descriptions such as key worker role
- ❖ Sharing information on specific disabilities and disorders

The Health Service Supports Survey responses indicate that some services are providing early educators and families with information booklets e.g. Disability Inclusion Booklets,

Writing Pack for Preschool, Welcome to Preschool Pack, and Information Sheets on Employing Preschool Assistant.



### Information leaflets are an example of:

(Based on Core Components of Early Services Associated with Positive Outcomes for Children and Families)

- Family Centred Practice
  - Natural context
  - Key Stage transitions
  - Access to Information      ✓
  - Key Point of contact
- Outcomes based
- Interagency collaboration
- Evidence based
- Systems based on guiding principles and values
- Governance and accountability

### **3.4 Open Evenings/Talks on a Specific Topic/Practical Strategies Workshops**

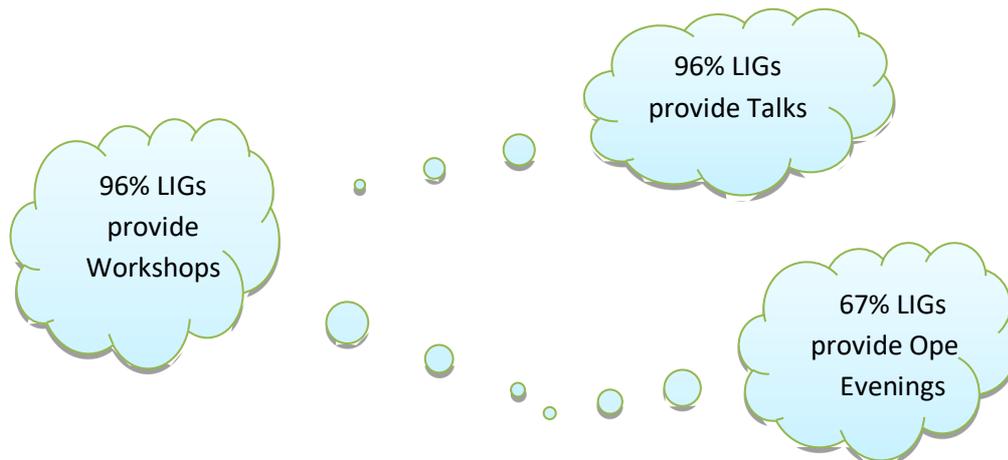
A significant proportion of survey respondents indicated that they provide open evenings/talks on specific topics/practical strategies workshops. The format for these events was not explored within the survey. The literature indicates that information events may include a conference style presentation, with didactic training. This is the most likely format for training provided in Ireland. Studies have shown that while this style of training has some merit, it is not engaging enough to have great value for many adults as the information can often be ‘flat and devoid of substance’ (Florea, 2014). Research indicates that there is a direct connection between the types of training received by educators and their classroom practice. Presentation style training was identified as the least effective for long term retention of the information. On-site training was identified as the most effective (Dunst and Rabb, 2010, Sexton et al., 1996, Tillery et al., 2010, Snell et al., 2012). Brown et al. (2014) describe Multi Component Training (MCT) strategies as a useful approach to training educators of children with severe disabilities. MCT is a combination of didactic presentation, follow-up coaching and role play with specific performance feedback.

#### ***Key Messages for Open Evenings/Talks/Practical Strategies***

#### ***Workshops***

- *High Quality and Effective training is a mix of training modalities*
- *Empowerment of educators leads to positive attitudes toward inclusion*
- *Training must be needs driven and person centred to influence engagement from the trainee*
- *Practical strategies training must be functional and appropriate to the needs of the child*

The Health Service Supports survey returns indicate that ....



The survey responses show that there are currently different types of training being offered to preschool providers with regard to universal supports.

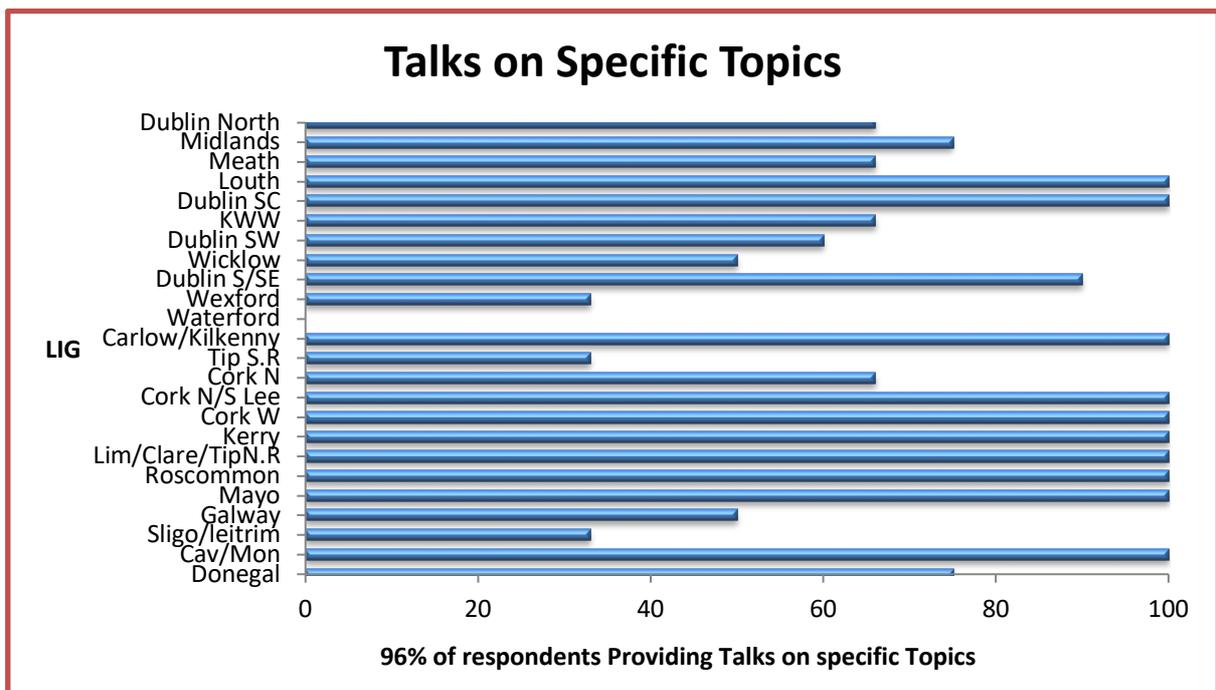
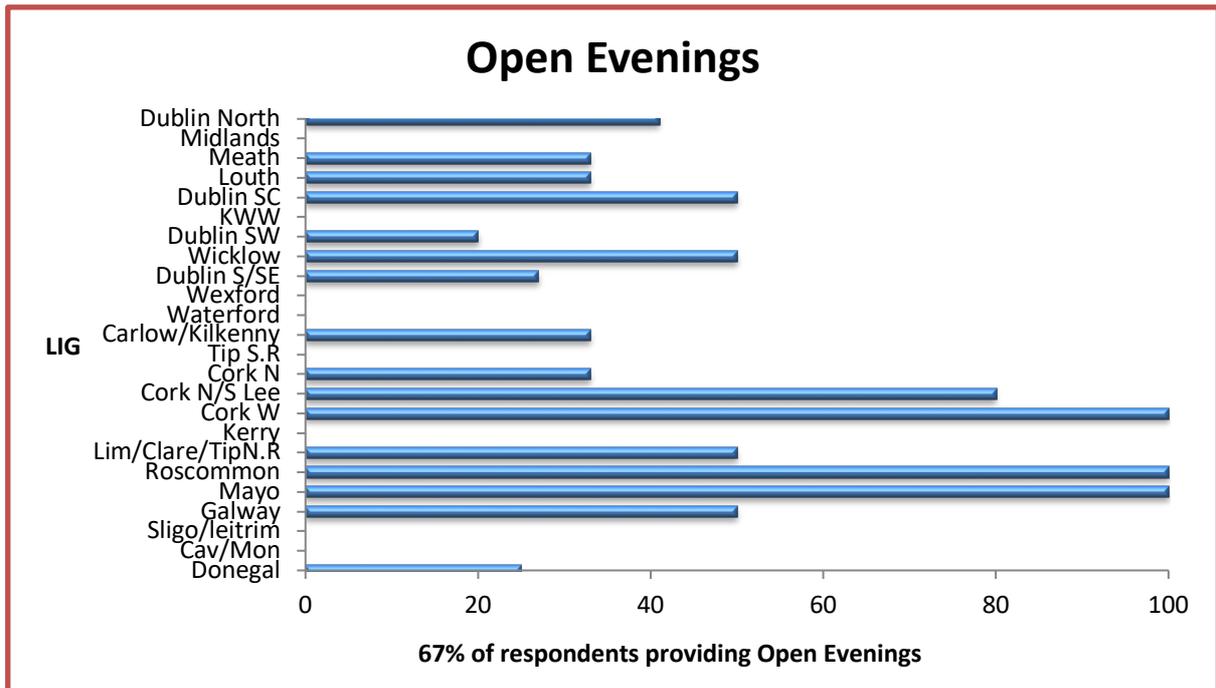
Respondents indicated that their services provide open evenings /talks on specific topics/practical strategies, examples from survey are below:

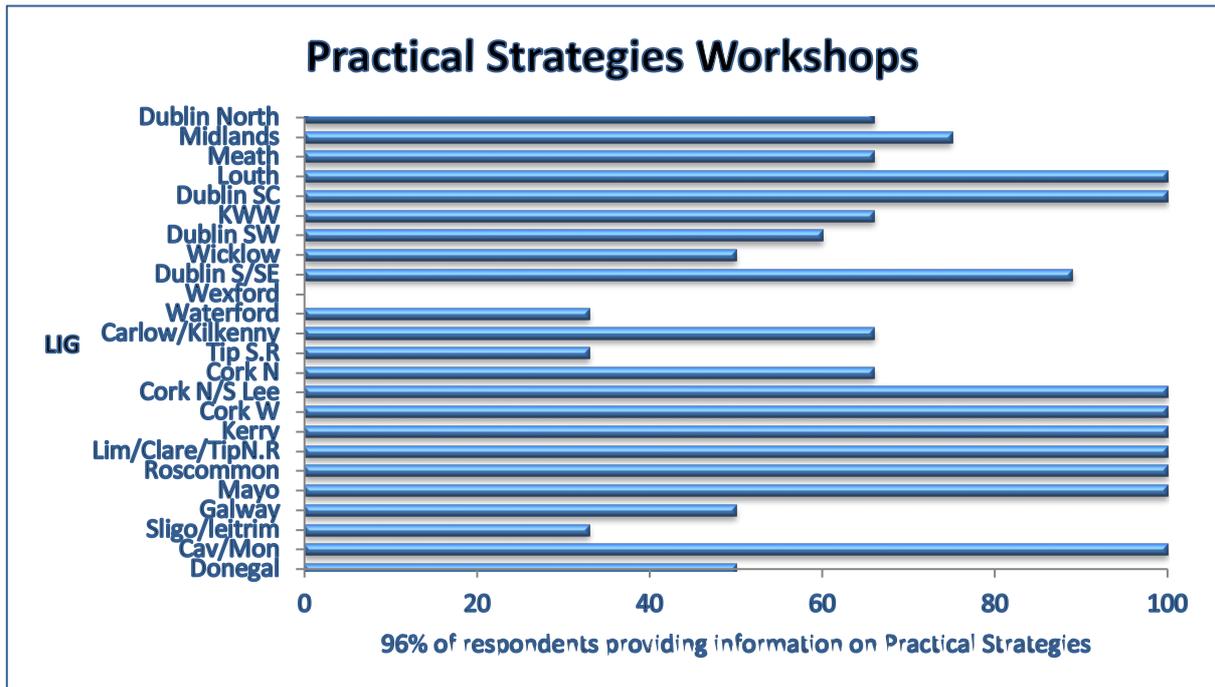
- ❖ Disability awareness Training,
- ❖ Information sessions on service delivery
- ❖ how to identify 'red flags' for development and ASD,
- ❖ how to communicate with parents around query diagnosis,
- ❖ development of communication skills,
- ❖ sensory processing in the classroom and
- ❖ development of fine motor skills, play and development,
- ❖ what is a learning disability
- ❖ supporting good behaviour,
- ❖ toileting,
- ❖ Training in response to needs
- ❖ Sensory workshops

- ❖ Demonstration of timers, visual schedules, choice boards, sensory materials

Respondents indicated training supports/topics are often tailored to early educators needs.

Some services have stated that they do not offer universal training secondary to staffing resources; others stated the intention of offering it in the future.





### Open Evenings/Talks on Specific Topics/Practical Strategies/Workshops are examples of:

(Based on Core Components of Early Services Associated with Positive Outcomes for Children and Families)

- Family Centred Practice ✓
  - Natural context
  - Key Stage transitions
  - Access to Information ✓
  - Key Point of contact]
  
- Outcomes based
- Interagency collaboration ✓
- Evidence based ✓
- Systems based on guiding principles and values ✓
- Governance and accountability

### 3.5 IEPs (Individual Education Plans)

IEPs (Individual Education Plans) are considered critical for children with additional needs attending an educational facility. This is particularly relevant when their additional needs are likely to affect their ability to achieve and learn. The purpose of the IEP is to provide an individually prepared education plan so that the child can achieve in their early education environment. An IEP is the product of consultation and collaboration between parents, the early intervention services, early year's practitioners and any other relevant personnel. The IEP serves as a road map for the individual child and should guide the integration of mainstream preschool education and the special education adaptation that the individual child with a disability may need (Dildine, 2010 cited in Liy, 2015). An IEP should be informed by the child's Individual Family Service Plan (IFSP). This information should be shared with all staff working with the child (Lipkin and Okamoto, 2015).

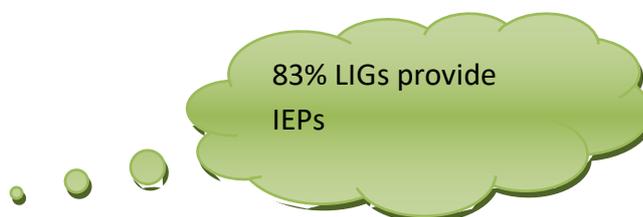
IEPs promote a "shared meaning" for members of a "team" focused on children with complex needs. This creates a holistic and clear service plan that is often less intrusive to the ecosystem of the child. It is an important influence in enabling children to meet goals and outcomes (Davis, 2007; Rossetti, 2001, Shonkoff, Hauser-Cram, Krauss & Upshur, 1992). Implementation of IEPs for children with complex disabilities requires a collaborative effort by those personnel working with the child including early years' practitioners, early intervention services and parents. The success of this collaborative effort to ensure the child's full participation in their preschools setting, in turn, depends on recurring opportunities for the child's 'team' to share their expertise, identify their shared goals, build the plans for support, determine and agree on responsibilities. This integrated accountability system can ensure a high level of consistent implementation of the IEP. Hunt et al. (2004) note: 'In terms of identifying and assessing children with SEN, *Ready to learn* highlights the benefits of multidisciplinary teams sharing recommendations and insights with ECCE practitioners. Such sharing is considered to be of 'immediate value in preschool and in schools in developing education plans for pupils with disabilities' (DES, 1999, p. 85). It specifies the need for curriculum, methodology, education plans and qualifications (Maloney and McCarthy, 2014)

### *Key messages for IEP*

- *IEPs specify the needs of a child with a complex disability, care and education*
- *IEPs service as a guide for the integration of mainstream and special education practice*
- *IEPs foster shared goals for a child with complex needs*

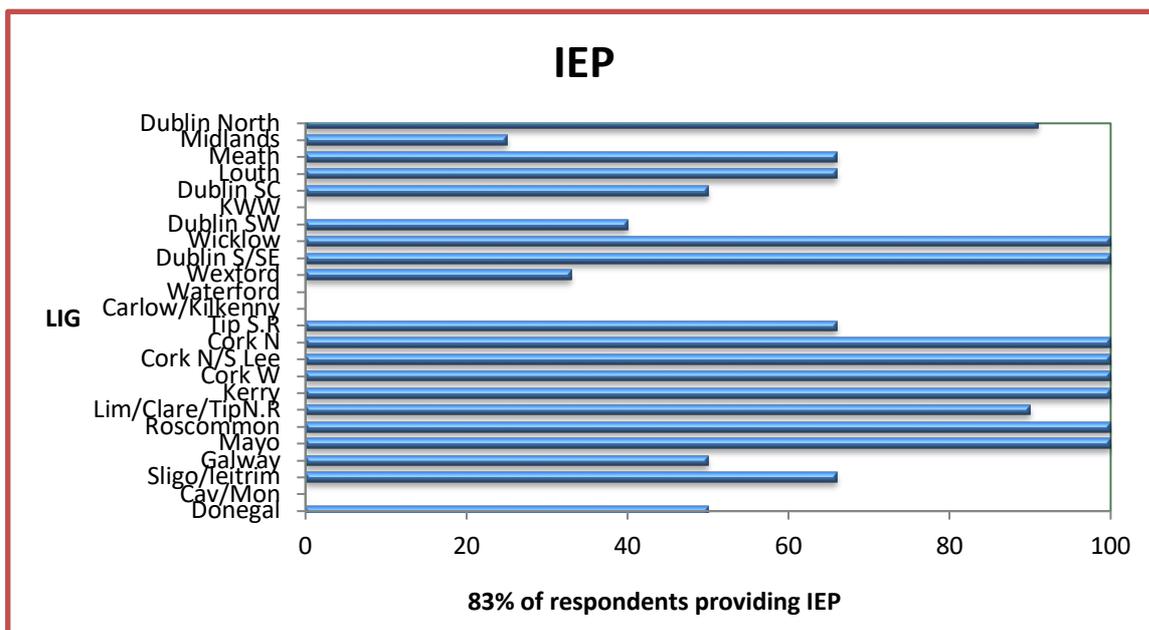
The Health Service Supports Survey

indicates ....



And that many of the health services in Ireland provide an IEP for children. The following is an example of reported IEPs:

- Copy of ICFSP (Individual Child Family Service Plan) with identified goals from all discipline involved given to preschool staff
- Support to preschool support workers include IFSP Plans re individual needs of children



*Individual Education Plans/Individual Preschool programmes are an example of:*

(Based on Core Components of Early Services Associated with Positive Outcomes for Children and Families)

- Family Centred Practice ✓
  - Natural context ✓
  - Key Stage transitions ✓
  - Access to Information ✓
  - Key Point of contact ✓
- Outcomes based ✓
- Interagency collaboration ✓
- Evidence based ✓
- Systems based on guiding principles and values
- Governance and accountability ✓

### 3.6 Individual Preschool Programmes

Family centeredness identifies the practice of sharing information about a child's treatment with the family. This ensures that information can be carried over into a child's home and preschool environment (Podvey et al., 2010).

There is a common agreement that specialised instruction based on the individual needs of a child with a disability is necessary. While the child might be attending a high quality early years setting with a good curriculum, it may not be adequate for the needs of the child with complex needs. Thus an individualised programme with specialised instruction is required. Specialised instruction should have the capability to be carried out in the child natural environment, preschool, and home, be activity based and allow for peer mediation. (Odom & Bailey, 2001). (Sandall, Hemmeter, Smith, & McLean, 2005). (Horn & Banerjee, 2009), (Ozen & Ergenekon, 2011), (Robertson, Green, Alper, Schloss, & Kohler, 2003).

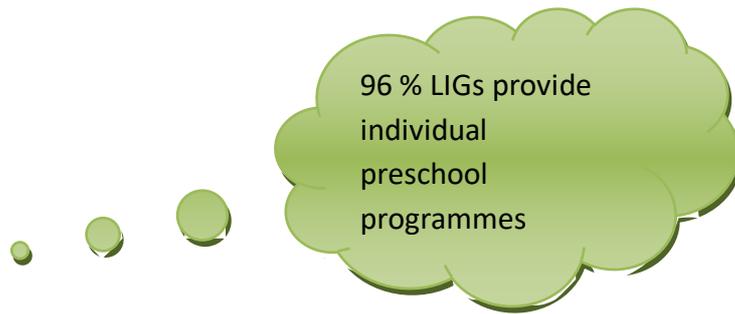
Individualized or differentiated instruction is described as best practice within inclusive early childhood education. This approach is consistent with a capability approach, which indicates that each individual has a unique set of capabilities and that relational interactions and structural interactions in the social environment affect the achievement of these capabilities.' (Underwood, Valeo and wood 2012).

#### *Key Messages for Individual Preschool Programmes*

- *Children with complex needs need individualised instruction*
- *Individual programmes should be devised with the child's natural environment in mind*

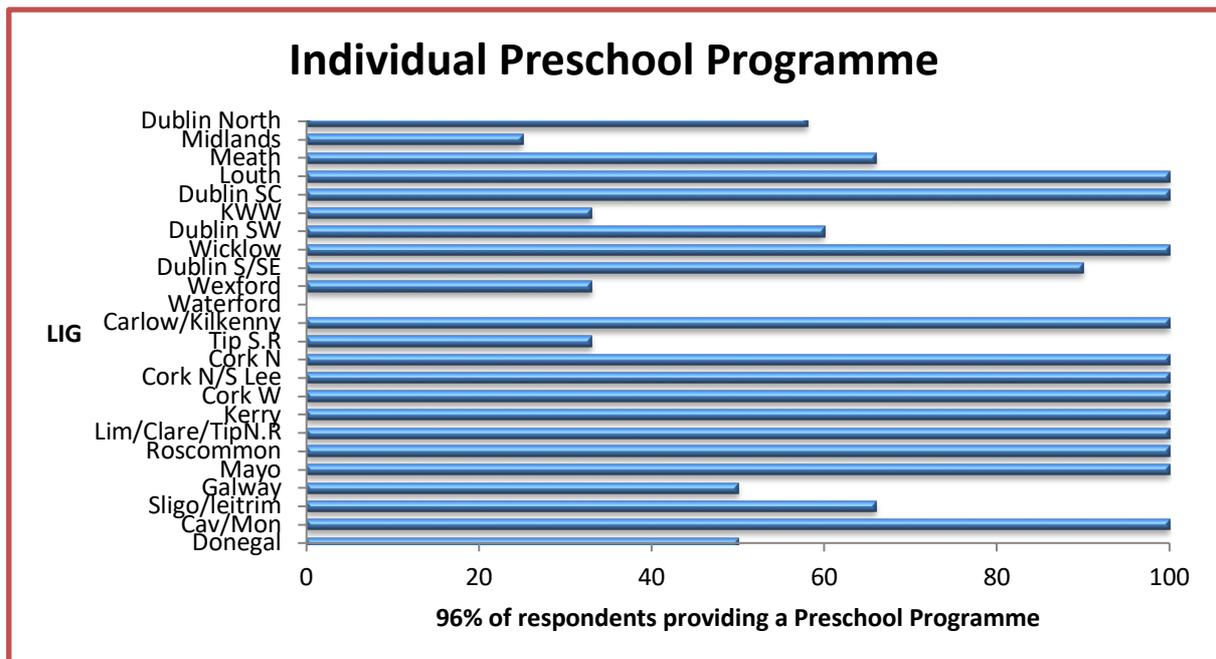
The Health Service Supports Survey returns

Indicate that....



Examples of responses regarding individual preschool programme:

- ❖ OT provide individualised programmes
- ❖ Programme given by all multidisciplinary members of the team involved with the child
- ❖ Integration programmes
- ❖ Preschool Liaison provide programme support
- ❖ Support for carryover of treatment programmes
- ❖ Individual programme and invite to team reviews



### 3.7 Preparing for Preschool/Transitioning

‘Planning for and providing coordinated support at key moments can help ensure better outcomes.’(Better Outcomes, Brighter Futures p. 8). A major transition in a young child’s life is the transition from their home environment or/and crèche environment to a preschool environment. Early Intervention health supports can smooth this changeover by working with the child and family through the inclusion of preparation for formal education in their intervention strategies. The therapist working with the family can support parents to shift their perspective on to the child needs for participation and adaptation to the preschool environment e.g. placing more emphasis on socially participating with their peers, making new friendships and an increasing focus on self-care skills such as eating independently. Teaching children social skills and organizational skills provides them with more competence to enter their new social and learning environment where are new routines to master and new relationships to engage in. (Pianta & Kraft-Sayre, 2003) (De Vore and Russell 2007)

As a family centred approach preparing for the preschool transition is fundamental. ‘Lovett and Haring (2003) describe four indicators of comfort during the transition for families:

- (1) the utility of the early intervention personnel in preparing families and setting up communication with school staff;*
- (2) families feeling involved in the development of their children’s IEP;*
- (3) families having opportunities for decision making related to their children’s IEP; and*
- (4) families feeling happy with their children’s pre-school placements.*

Each of these indicators of comfort describes events that occur before the child’s first day of school (Podvey et al., 2010).

Bruder and Chandler (1996) note a successful transition; is a series of well-planned steps to facilitate the movement of the child and family into a different service mode, without any disruption of intervention services. The type of planning and practices that are employed can influence the success of the transition and the satisfaction within the transition (Bruder, 2012). The timing of the intervention practice can often differentiate between a ‘transition’ practice and a practice used in general intervention and classroom instructional practice.

Rous & Hallam, (2012) report successful transitions are considered part of the delivery of high-quality early education services for young children with disabilities and their families. The study of the transition process and implementation of transition practices can be strengthened by integrating transition in to a broader framework of planning and by implementing seamless services for young children, birth through to formal school entry. The coordination of all relevant services surrounding the child at their time of transition is considered vital the support the child with developmental delay and disability (Clark and Crandell, 2009).

**Key Messages: Transitions**

- *Preparation, planning and provision of support to child and family prior to entering preschool environment, is the key to a smooth transition*
- *Collaboration and coordination between agencies can help to reduce stress, meet family's needs and increase the chances of a positive transition outcome*

The Health Service Supports Survey returns

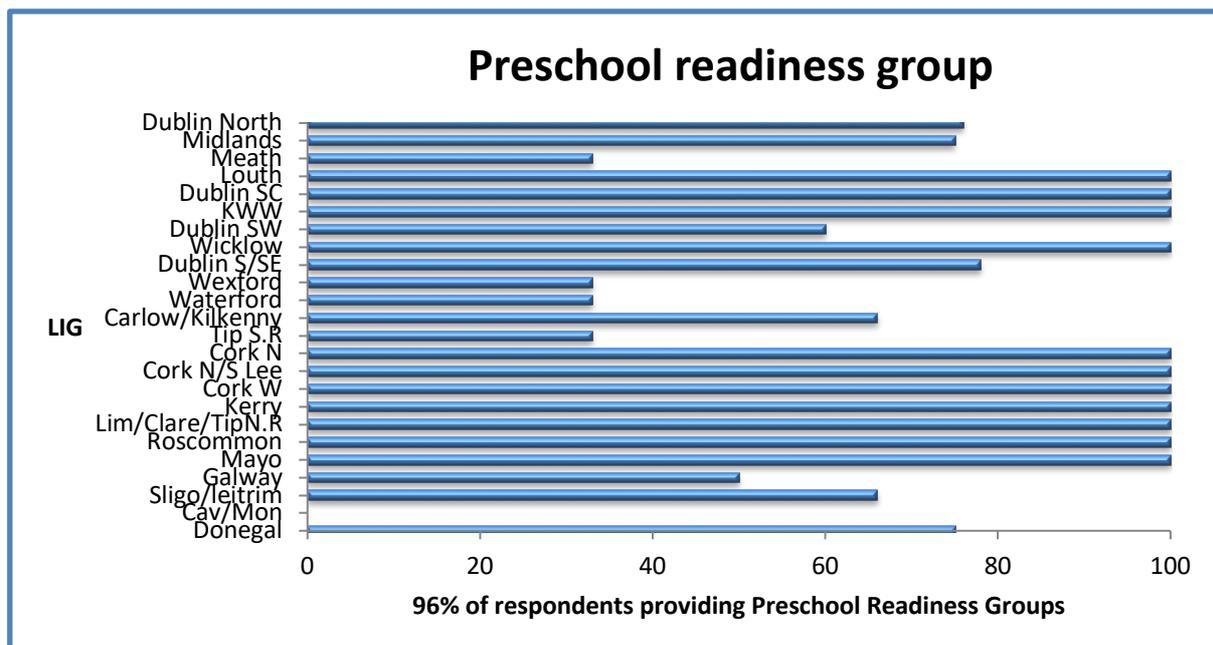
Indicate that ....



96% LIGs provide  
Preschool  
Readiness groups

Survey responses indicate that there are currently different types of supports being offered to preschool providers with regard to preparing children with a disability for preschool. The following is a list of reported preschool preparation strategies:

- ❖ Visits to preschool prior to child starting
- ❖ Visits to preschool where there are equipment needs
- ❖ Transition to school report when child is transitioning from preschool to school
- ❖ Assessment of the school environment suitability
- ❖ Support visits
- ❖ Recommendations and individual programmes
- ❖ Transition meetings with parents
- ❖ Supporting families to find a preschool placement
- ❖ Early childhood groups .e.g. social skill groups, preparing for preschool groups
- ❖ Interdisciplinary support to facilitate placement e.g. adaptation of environment, purchasing of equipment
- ❖ Identifying support needs (of the child and family generally)
- ❖ Advice and support around participation in the group



## Preschool Readiness Groups are an example of

(Based on Core Components of Early Services Associated with Positive Outcomes for Children and Families)

- Family Centred Practice ✓
  - Natural context
  - Key Stage transitions
  - Access to Information
  - Key Point of contact
- Outcomes based ✓
- Interagency collaboration ✓
- Evidence based ✓
- Systems Based on guiding principles and values
- Governance and accountability

### *Key messages for Preschool Visits and Telephone Contact*

- *Interventions should be embedded in a child's daily routines and activities in their natural environments*
- *Therapeutic intervention and adaptations are essential for inclusion in mainstream settings*
- *Timely communication is necessary for sharing ideas and sharing information to support inclusion*

The Health Service Supports Survey returns indicate ....

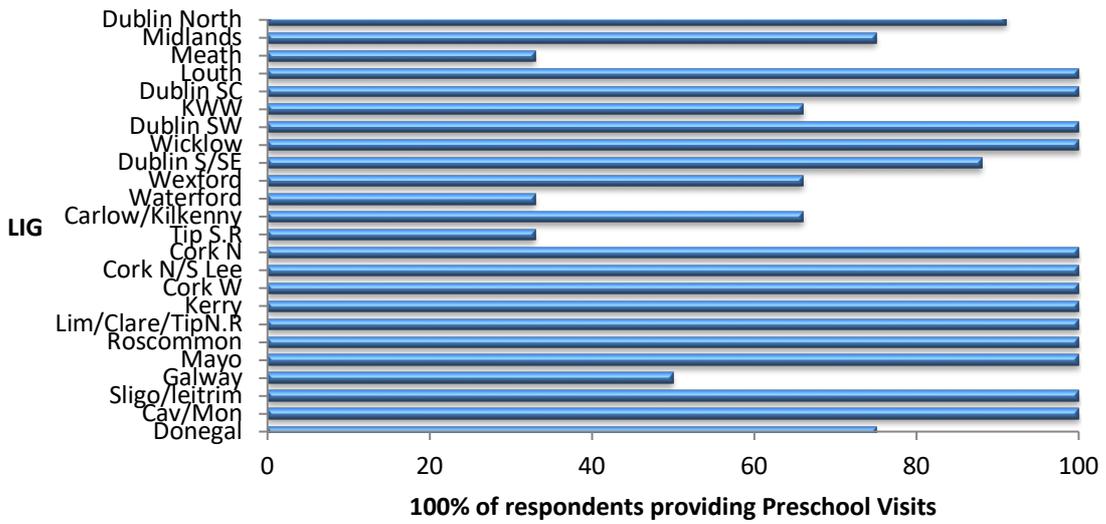


Survey responses confirm that many services in Ireland are providing preschool visits:

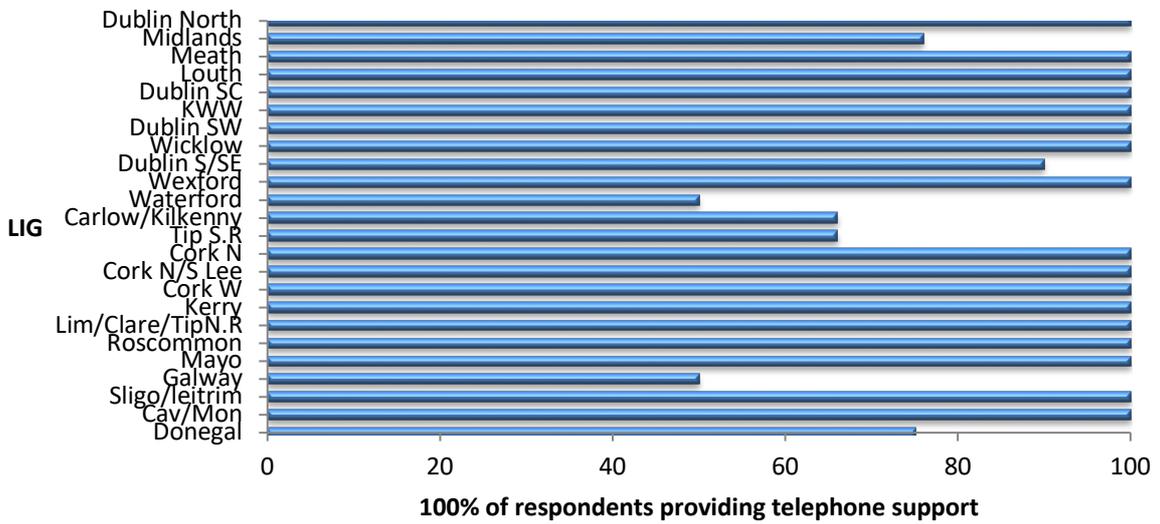
- ❖ Preschools can make contact where there are queries or concerns

- ❖ Visits to preschool re the use of equipment e.g. hoists
- ❖ Visits to assess the preschool environment
- ❖ Visits prior to child starting preschool
- ❖ Visit to support staff
- ❖ Visits by clinical staff to create preschool programmes
- ❖ Regular visits to preschool and telephone links
- ❖ Visit by key worker
- ❖ Visit by clinician to outline the difficulties the child has, the impact of same on the child and to go through the programme prepared for the child
- ❖ Observations in preschool
- ❖ Working collaboratively to support children's early development
- ❖ Liaising with preschool staff to give advice and recommendations
- ❖ Early Years Educators link between preschool and team
- ❖ Needs based approach to provision of support to preschool
- ❖ Advice over the telephone
- ❖ Visits and ongoing consultation by phone
- ❖ Ethos is to provide intervention in the child's natural environment
- ❖ Joined up and collaborative approach between preschool and health staff
- ❖ Visits to support staff to adapt the preschool curriculum to suit the child's learning needs
- ❖ Visits to preschool to engage in ongoing partnership with the preschool

### 3.8 Preschool Visit



### Telephone Support



### **Preschool Visits and Telephone Support are an example of:**

*(Based on the core components of Early Services associated with positive outcomes for children and families)*

- Family Centred Practice ✓
  - Natural context ✓
  - Key Stage transitions ✓
  - Access to Information ✓
  - Key Point of contact ✓
- Outcomes based ✓
- Interagency collaboration ✓
- Evidence based ✓
- Systems based on guiding principles and values
- Governance and accountability

### **3.9 Invitation to Therapy Session**

Inviting an early educator to an early intervention treatment session can provide a health professional with the opportunity to model their practice, share knowledge and skills. It can also assist in building the early years educators skills and confidence when implementing the practice with the child in the classroom environment. This opportunity to observe and then apply the practice, followed by feedback is known to positively influence the adoption and implementation of the recommended supports for children in their natural environment i.e. the preschool playroom (Dunst and Rabb 2010). It is recognised that adults assimilate knowledge best when they are directly involved in the experience. (Florea 2014).

*Key messages for early educators attending clinical sessions*

- *By inviting an early years practitioner to a therapist session, therapists have the opportunity model their practice and share their knowledge*
- *By attending a therapy session the early years practitioner can observe and experience the practice of the therapist*
- *Observation and application of a practice can positively influence the implementation of it*

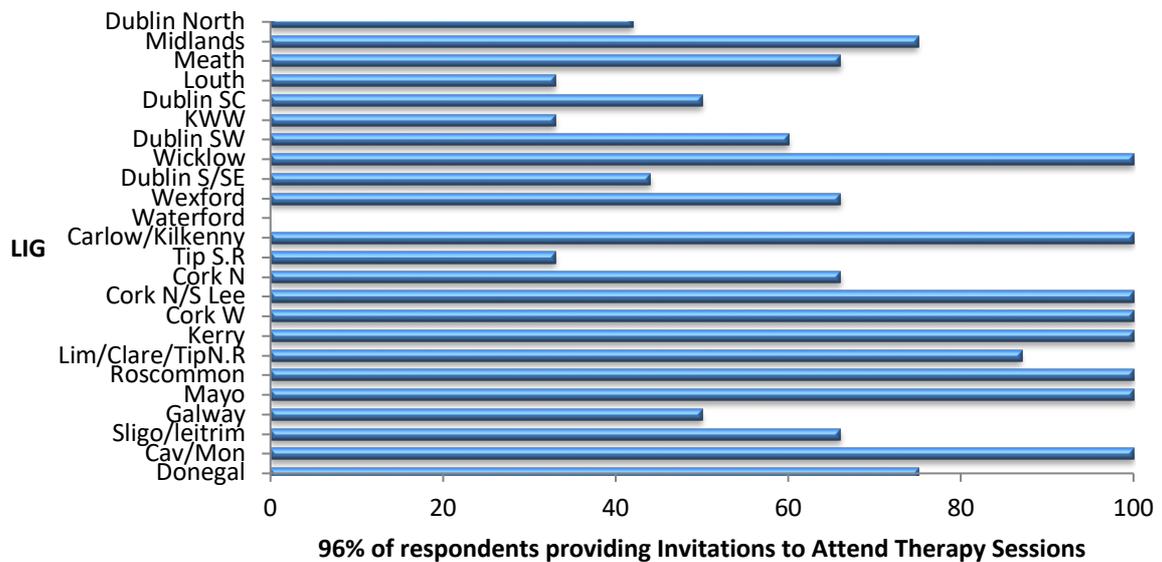
The Health Service Supports Survey returns indicate that .....



The following is an example of reported 'Invite to a session':

*Opportunities for mainstream preschool staff to attend a special preschool setting and observe the routines/strategies used with specific children in order to transfer it to the mainstream setting.*

## Invitation to Attend Therapy Sessions



### **Invitations to attend Sessions at the clinic are an example of:**

(Based on Core Components of Early Services Associated with Positive Outcomes for Children and Families)

- Family Centred Practice ✓
  - Natural context
  - Key Stage transitions
  - Access to Information ✓
  - Key Point of contact ✓
- Outcomes based ✓
- Interagency collaboration ✓
- Evidence based ✓
- Systems based on guiding principles and values
- Governance and accountability

### 3.10 Evidence Based Practice

Evidence based practices are defined as:

*Practices that are informed by research, demonstrate a relationship between the characteristics and consequences of a planned, or naturally occurring, experience or opportunity; where the nature of the relationship directly informs what the practitioner can do to produce a desired outcome*

Accessing relevant information on evidence based interventions can be a barrier to implementing evidence based interventions (ARACY, 2015). Information can be sought through a number of different sources. Below are examples of where information may be accessed and how to find it.

#### Key Messages for evidence based practice

- Evidence based practices will have a limited impact if not effectively implemented
- The capacity of practitioners and organisations to work in an evidenced way are a strong determinant of impact of the intervention
- The extent to which systems are ready and able to support evidence based practice is also a strong determinant of impact

#### USEFUL WEBSITES

##### Google Scholar

HSE library [WWW.HSELibrary.ie](http://WWW.HSELibrary.ie) The library has access to several data bases. It can also provide support regarding a specific clinical question. You can apply for an Athens log in through HSE library.

HSELand is an online resource designed to support the training and development of staff working in the Irish health sector.

NICE: The National Institute for Clinical and Care Excellence –provide clear practice guidelines that are grounded in evidence about the components of good practice.

### **3.11 Training/Professional Development**

There is a growing diversity of the population of children receiving early childhood intervention in Ireland (e.g. racial, ethnic, linguistic, and, most important, types and severity of disability). This challenges interventionists to establish a larger and more flexible skill set including which includes individualized (and sometimes aetiology specific) instructional proficiencies. Effective, ongoing in-service training must be available to all who provide services in early childhood intervention which includes the early years practitioner who is expected to carry out individual programmes for children with developmental delay and disability within their early education curriculum. The in-service opportunities provided for all those working with young children must meet ‘Evidence-based adult learning standards’ and the content must communicate the competencies needed to undertake the achievement of identified child and family goals and outcomes. (Bruder et al., 2009, Snell et al., 2012, Feil et al., 2009, Sexton et al., 1996; Snyder & Wolfe, 2007).

The health support survey requested information on the following training: Lámh, PECS, Hanen, EarlyBird Plus, Sensory Integration, Postural Management, Manual Handling and DIR Floortime, the following pages outlines each from an evidence based perspective.

It should be noted that the list of Training Options mentioned here is not in any way exhaustive and there are other evidenced based training such as Stepping Stones Triple P, Marte Meo, Parents Plus, and Common Sense Parenting among others which are of equal value. However, as these were not mentioned in the survey returns they have not been researched for this project.

### **3.12 Hanen**

The *It Takes Two to Talk* Program is designed specifically for parents of young children (birth to 5 years of age) who have been identified as having a language delay. In a small, personalized group setting, parents learn practical strategies to help their children learn language naturally throughout their day together (Hanen Centre). This programme supports parents to take on a more ‘responsive approach to interaction’ (Pennington 2009) The

*Learning Language and Loving It* Program was designed to provide early childhood educators with practical strategies for helping all children in the classroom build language and social skills, no matter what their learning and communication styles are, and even if they have special needs.

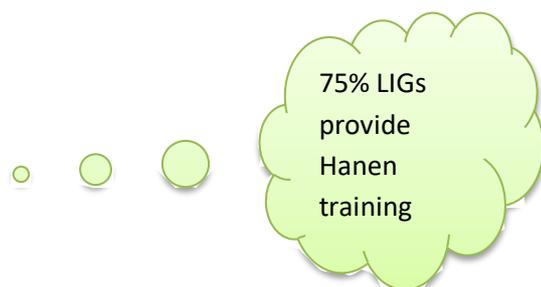
This programme is found to increase participant's language skills and increased positive social responsiveness. Research also has shown The Hanen Programme supports participants to reduce their initiation interactions, produce more responses and reduce requesting. In turn the children increase their initiatives, requesting and provision of information. (Weitzman, 1992, Girolametto, 2003, Pennington et al., 2009)

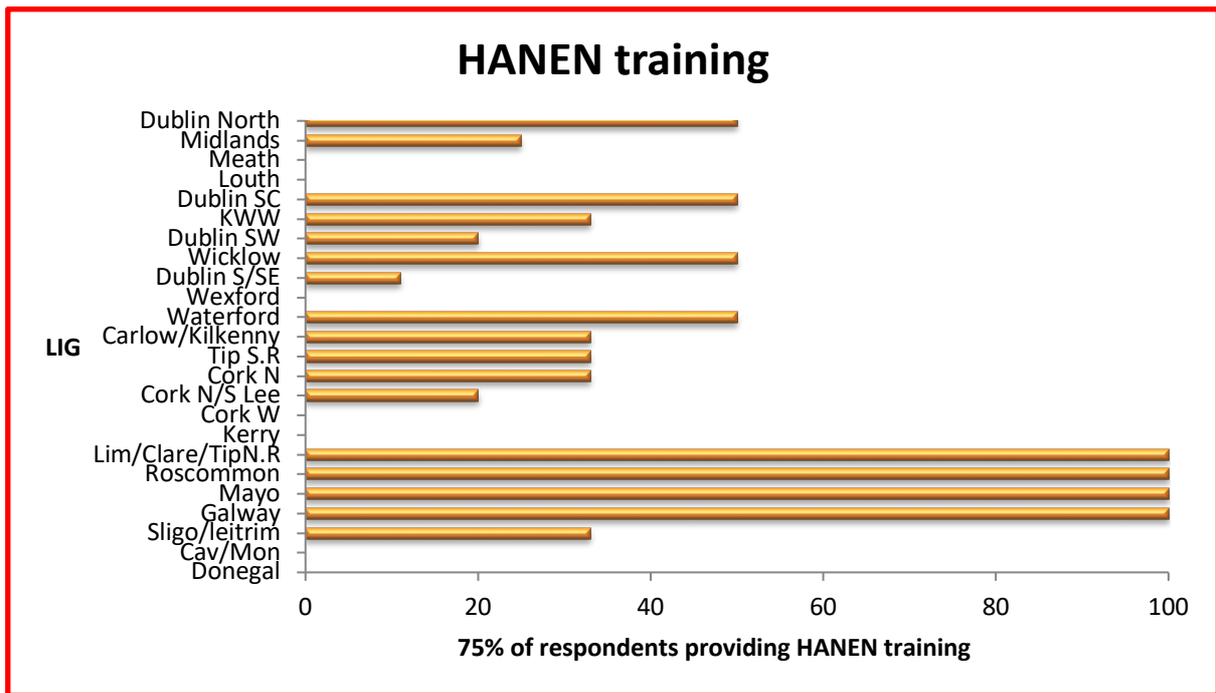
### Benefits

- Increased communication skills for both parents/carers and child
- Promoting every child's language development using natural everyday activities, routines and play
- Becoming attuned to children's interests so you can follow their lead, which is known to foster language development
- Adjusting the way you talk to help children develop more advanced language skills
- Promoting interaction among the children themselves
- Facilitating language-learning in pretend play

The Health Service Supports Survey returns

Indicate that.....





Website for Hanen Information: [www.hanen.org](http://www.hanen.org)

### 3.13 Lámh

Lámh is a manual, key –word signing system, which is adapted from ISL (Irish sign Language) to provide children and adults with an intellectual disability with an alternative communication. It is also used by children who have communication delay and their families. Using manual signs gives a child or adult a multi modal approach to receiving and giving messages; hearing seeing and feeling (Clerkin, 2009).

It is recommended that Lámh is introduced as a communication system as early as possible. Parents, health service professionals and early years educators are advised to develop their understanding of the structure of Lámh’s sign to ensure they can identify attempts made by the child who is learning the sign. As a result the child’s communication partner will be in a position to comment and expand on these attempts (Powell G., 1999)

There are challenges to the use of Lámh; lack of courses, societal awareness and limited vocabulary. Lámh users are limited to using it in an environment where other people know the signs are and are willing to use them (Linehan, 2016). Research suggests that the use of

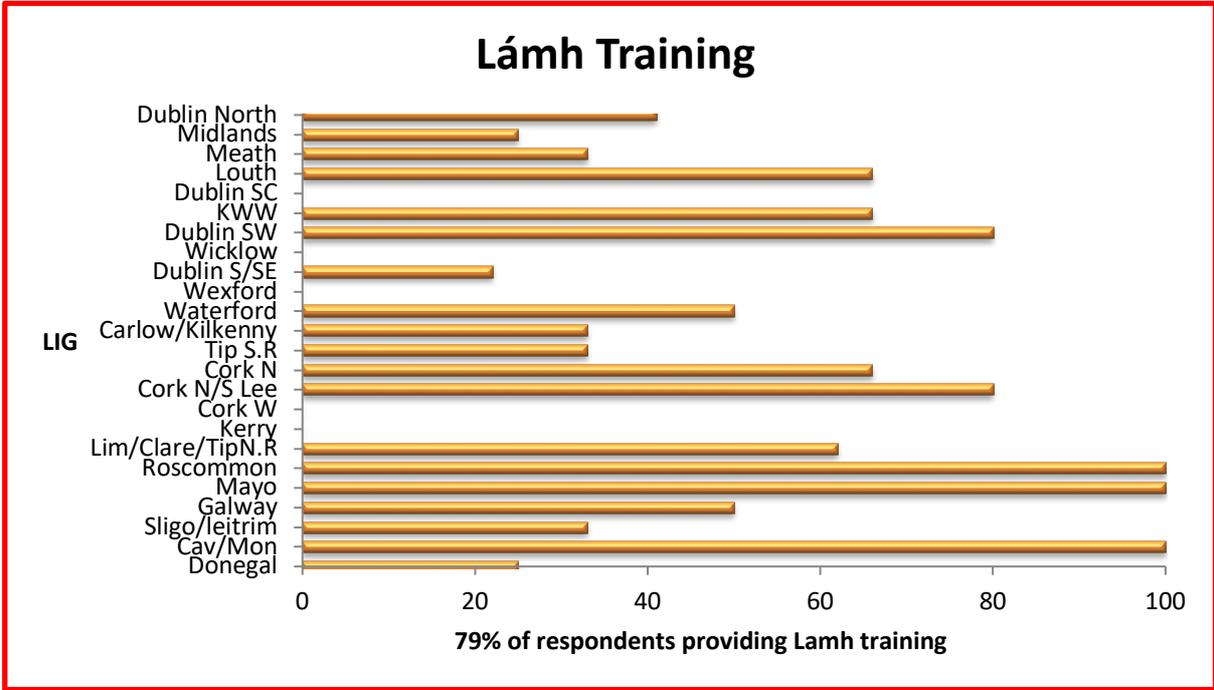
Lámh is valued among Lámh users' and their peers. However difficulties in use arise in unstructured situations such as the playground and also adherence to the fidelity of the sign structure (Bowles and Frizelle, 2015).

Benefits

- Alternative means of communication
- Reduces language to key words
- Multimodal approach to communication

The Health Service Supports Survey returns

indicate that.....



Information Website: [www.lamh.org](http://www.lamh.org)

### 3.14 Picture Exchange Communication System (PECS)

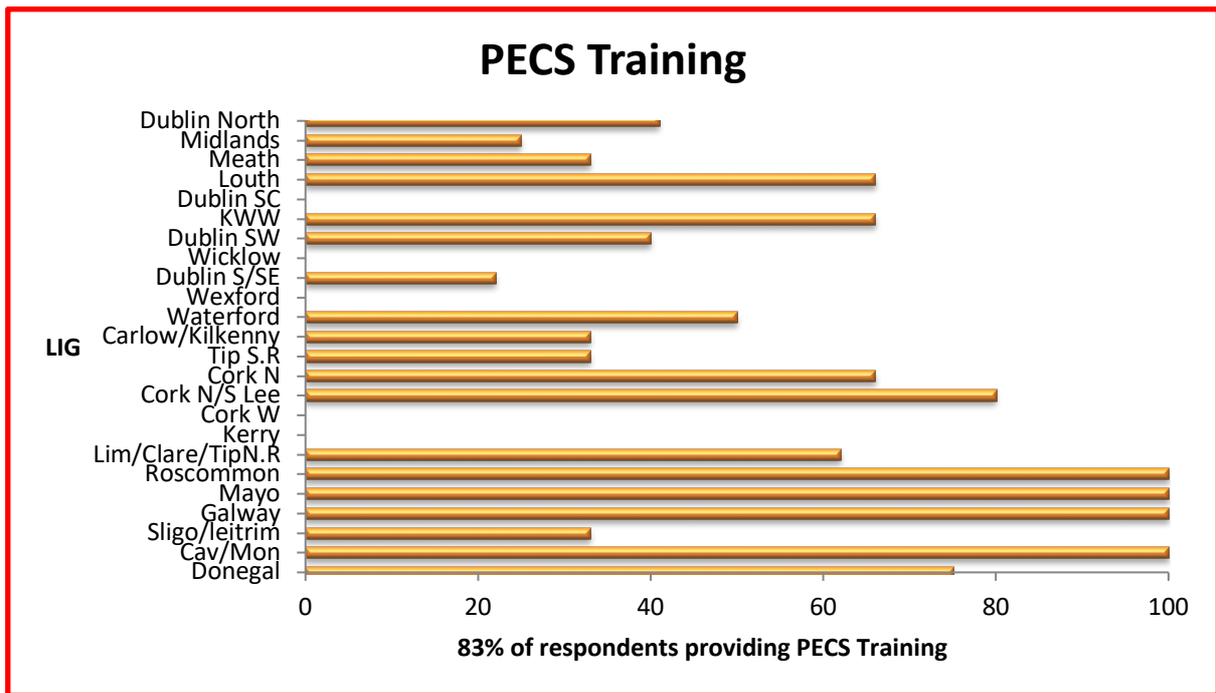
Picture Exchange Communication System (PECS), is a picture based procedural package to teach children lacking spoken language skills to initiate requests and to describe what they observe. This is a programme designed for early communication training which can be used in the home and other natural settings (Azarof et al., 2009). The results of evidenced- based research show that PECS improves meaningful and social communication for most participants and help them to gain a functional communication vocabulary (Azarof et al., 2009, Travers et al., 2016).

The benefits for many children who use PECS as a communication system are shown as:

- Increase in social communication
- Better quality of life
- Increase in self-determination
- Decrease in disruptive behaviour PECS Training

The Health Service Supports Survey returns indicate that.....



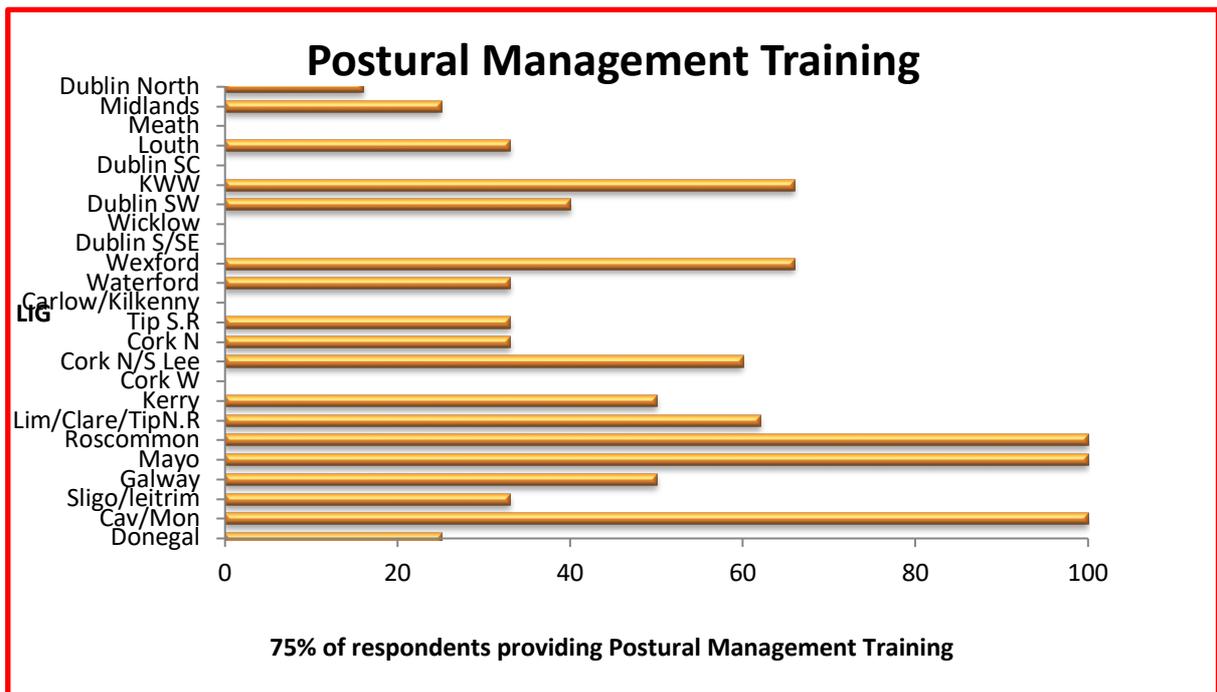


### 3.15 Postural Management (PM)

An expert multidisciplinary group defined a postural management programme for children with Cerebral Palsy (CP) as a planned approach encompassing all activities and interventions which impact on an individual’s posture and function (Gerricke, 2006). The main devices used in a consistent postural management programme other than stretching and orthoses are night-time postural systems, specialised seating and standing frames. There is a current shift in focus from body structure to an approach that encompasses the child, their environment, and their present and future needs (Gough 2008). A study by Mc Donald et al. (2007) noted that therapists focused on how the seating system would impact on the posture and body structure, while parents’ focused on the ease of use, the transportability of the device and the comfort level of the child using the device. The evidence available suggests that parents and carers may not be faithful to a treatment if it is painful for the child or seen to be lacking practical gains (Gough 2008).

The Health Service Supports Survey returns indicate that.....

75% LIGs provide Postural Management Training



### 3.16 Sensory Integration (SI)

Sensory Integration (SI) is related to how the body manages and processes the sensory inputs from the surrounding environment. Sensory based therapies have been devised to treat sensory dysfunction which occurs when 'sensory neurons are not signalling or functioning efficiently, leading to deficits in development, learning and/or emotional regulation' (Zimmer & Desch 2012).

SI therapies are among the most common interventions for children with ASD used by Occupational Therapists. Evidence based research shows that SI therapies should be treated with caution as the evidence for its effectiveness is inconclusive (Lang et al., 2016).

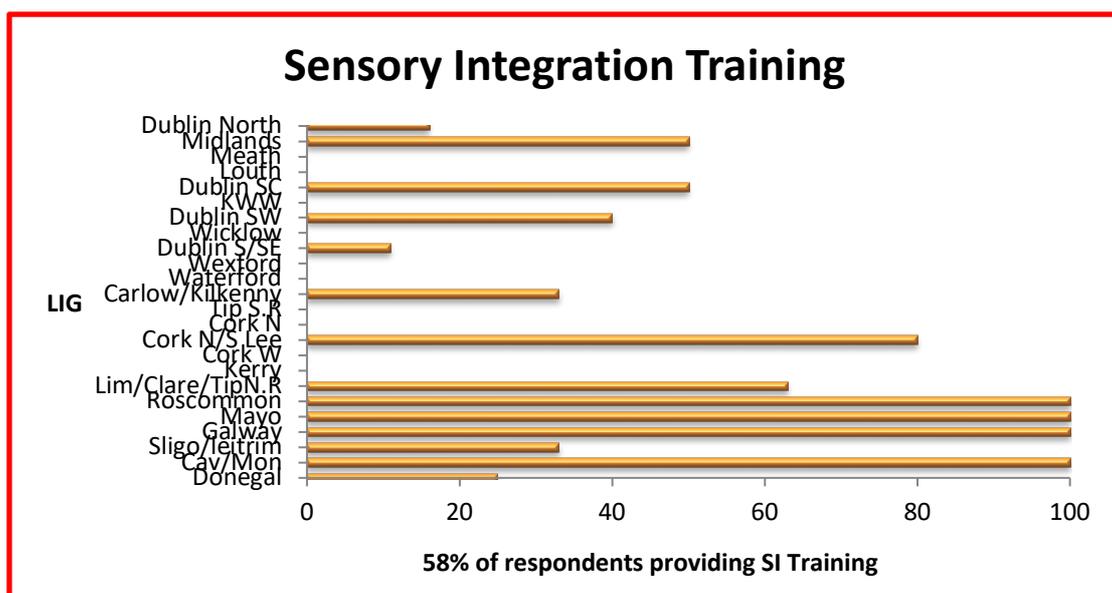
One of the limitations cited regarding studies relating to SI is the lack of fidelity measures which ensure the validity of the interventions provided.

There is some evidence to show SI's effectiveness reducing self-stimulating behaviour and increasing social interaction and play in children with ASD (Pfeiffer et al., 2011). SI has also been found to have an impact on individualised goals for children with ASD (Case-Smith et al., 2015). Losinski et al. (2016), suggest that Deep Touch Pressure, a sensory integration intervention, an example of which is the use of weighted vests, had 'little, if any positive effects, and in some cases some negative effects'.

### Benefits of SI

- Control sensory experiences
- Improve sensory modulation related to behaviour and attentions difficulties
- Increase capacity for social interactions, learning and independent daily living

The Health Service Supports Survey returns indicate that.....



### 3.17 Early Bird Plus

The National Autistic Society's Early Bird Plus (EBP) programme was devised to offer support to parents and carers of children with a diagnosis of an ASD. The focus of the EBP programme is on those children who receive a diagnosis; specifically when aged between four years and eight years, 11 months and are attending an educational facility; early education centre or school. The three main strands of the programme are; what is ASD, communication and ASD and behaviours and ASD. Parents and carers and a professional from school attend the training together to identify and address the needs of both the home and school settings and develop a consistent approach to the needs of the child.

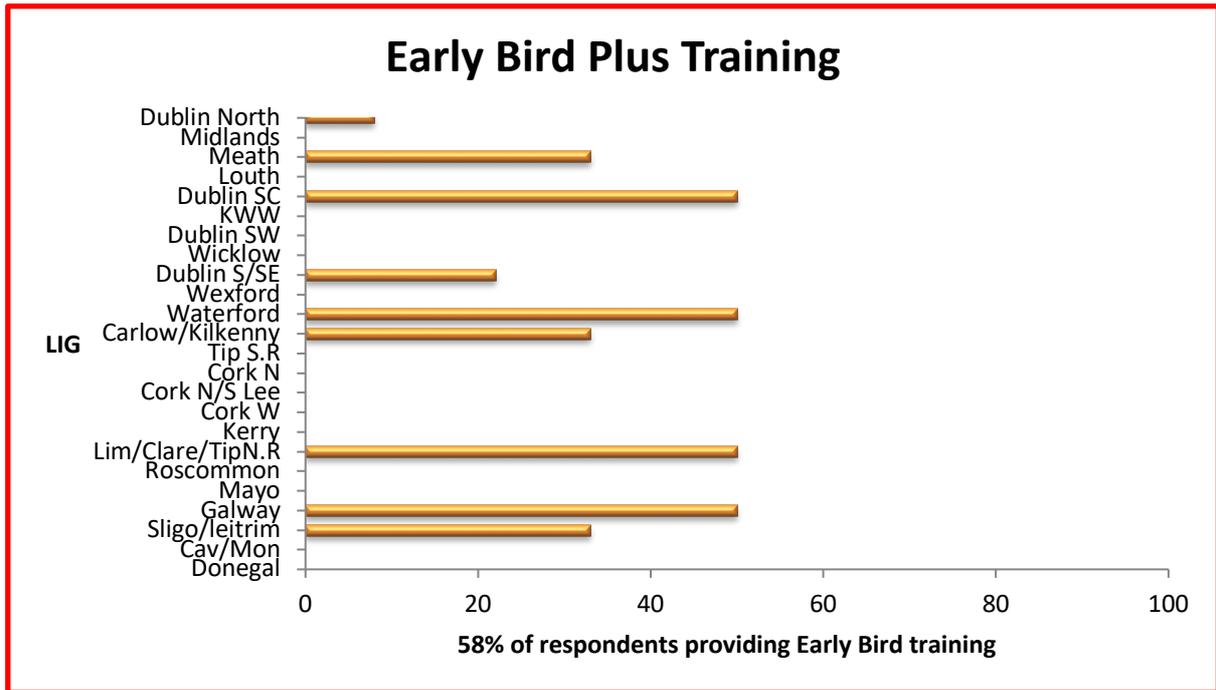
Studies have established EBP inspires confidence in parents with regard to their enhanced ability to cope and communicate with their children. Research also reports that participants gain an increased understanding of ASD. They were reported to acquire strategies that helped the child develop communication skills. In addition participants gained knowledge with regard to managing behaviours and increased coping abilities. However, little research exists as to the impact EBP has on schools in terms of its inclusive practice and attitudes around ASD (Cutress and Muncer, 2014).

#### Benefits

- ❖ Increased understanding of ASD; the why and how
- ❖ Communication strategies
- ❖ Behaviour management strategies
- ❖ Opportunity to develop relationships between child's parents and educators

The Health Service Supports Survey returns indicate that .....





Information Website: [www.autism.org.uk/earlybird](http://www.autism.org.uk/earlybird)

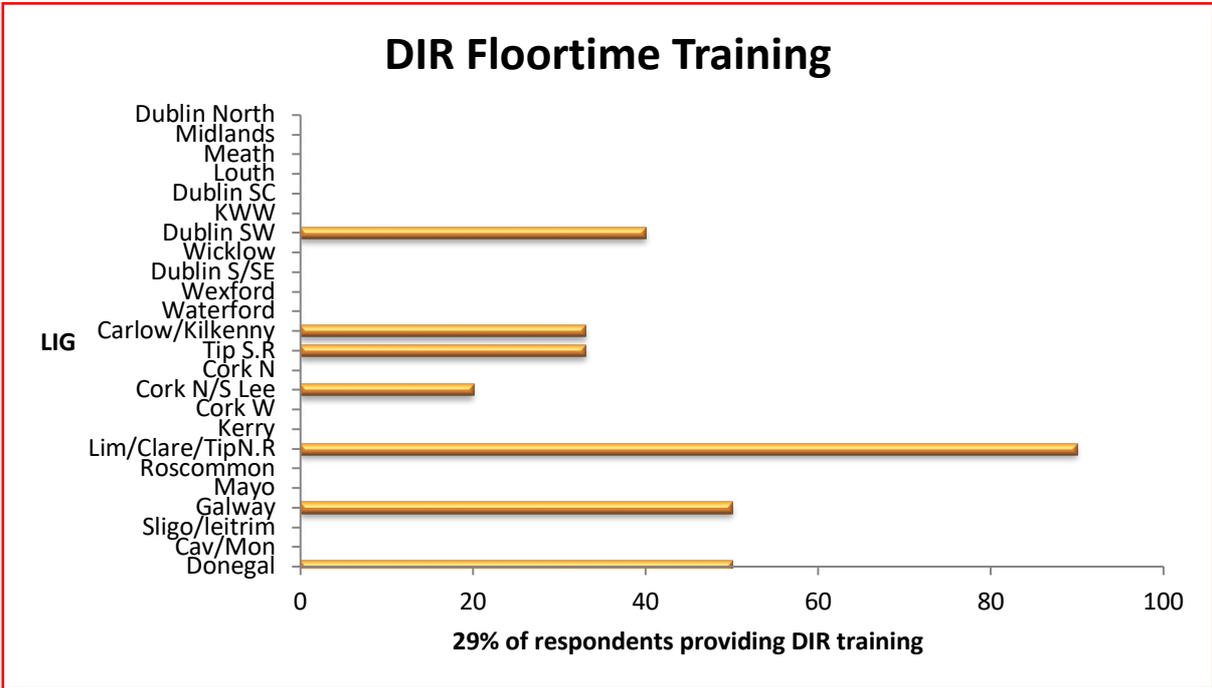
### 3.18 DIR® Floortime™

DIR is a Developmental, Individual-differences, & Relationship-based model. The DIR® model is a framework supporting clinicians, parents and educators conduct comprehensive assessments and develop educational and/or intervention programs tailored to the unique challenges and strengths of each child. DIR Floortime® is the application of the DIR model into practice (The Interdisciplinary Council on Development and Learning (ICDL))

Greenspan and Brienbauer (2005) report that a pilot study on DIR Floortime indicates that this the application of this model has positive impacts on following the child’s lead, harnessing the child’s emotional interests, creating interaction and moving to higher functional emotional development levels. Research on DIR/Floortime has given some support to the effectiveness of this intervention for children diagnosed with ASD. This is particularly true for non-language measures such as interaction skills, functional development and autistic symptoms (Mercer, 2015.). Hess (2013) notes that research into the effectiveness of DIR® Floortime™ should continue, however, this intervention should

remain an option for families supporting children and adolescents with developmental delays.

The Health Service Supports Survey returns indicate that .....



Information website: [www.icdl.com](http://www.icdl.com)

### 3.19 Parent Training

There is strong evidence that parental behaviours are modifiable when provided with high quality parental input. This is particularly evident when for parents of children with an identified behavioural need. There is consistent evidence that parenting behaviour is associated with positive child development, improved social and emotional wellbeing.

A parent training programme can be described as an intervention where parents actively gain parenting skills and the programme may or may not have educational components.

Many parent training programmes do include an instructive component which is a passive educational approach. Decades of research have shown that a programme which 'contain active learning approaches are superior to passive approaches' (Arthur et al., 1998; Joyce and Showers 2002; Salas and Cannon-Bowers 2001; Swanson and Hoskyn 2001, Kaminski et al., 2008).

Children with developmental delay and intellectual disability are 'three or four times more likely to present with clinically significant behaviour problems' which are externalised. (Roberts et al., 2006). Disruptive behaviour, aggression, oppositional behaviours and non – compliance are the most common problems for which parents and educators seek professional mediation. Parent training as mediation for such behaviours is based on the evidence that parenting practices contribute to 'genesis, progression, and maintenance of disruptive behaviours across childhood (Lundahl et al., 2006).

There are a range of topics for parenting programmes for parents of young children delivered by early intervention services e.g. communication, child development, positive parenting, behaviour management. Whether the programme is manualised or not is not as important as the components included to determine the outcomes. (Westen et al., 2004). In a study by Kamiskinsi et al. (2008), the most robust components which predicted better parent and child outcomes were noted as; discipline, teaching positive interaction, teaching emotional communication skills and parents having practice sessions with their child during training sessions. The latter is a naturalistic approach rather than parent attempting to generalise skills learning in other settings. Another benefit is the opportunity for the parent training facilitator to give immediate reinforcement and corrective feedback if needed. 'Learning in context is more effective' (Hattie et al., 1996).

Effectiveness of parent training can also vary depending on the individualities of the parent training participant such as family adversity, their socioeconomic status, unstable housing, single parent status, young parent age and reliance on government subsidies. Any of these can disrupt the participant's ability to participate in the training process and the implementation of the programmes recommendations ((Lundahl et al., 2006). Although

there are a variety of worthwhile parent training programs in current use, evidence based parent training programs for externalizing disorders have several shared characteristics which include a robust behavioural basis and an emphasis on the transfer of skills to parents, thus recognising that they are the primary agent of change for their child. (Chambless and Ollendick, 2001).

How parent training is delivered has to be weighed against the evidence also. Evidence has shown that while group training provides social support to those families who frequently lack a social support structure, on the other hand individually delivered training can be tailored to individual needs and be flexible in that delivery. This is particularly relevant to families facing financial disadvantage (Lundahl et al., 2006).

Examples of Parent Training currently in use in Ireland are:

Parents Plus: [www.parentsplus.ie](http://www.parentsplus.ie)

Incredible Years: [www.incredibleyears.com](http://www.incredibleyears.com)

Triple P: [www.triplep.net](http://www.triplep.net)

**Please note: Parent Training was not included as an enquiry for Health Support Survey**

#### **Key Messages for Parental Training**

For best outcomes behavioural parent training should include the following approaches

- discipline strategies
- promoting positive interaction
- promoting emotional communication skills
- opportunities for parents to have practice sessions with their child during training sessions
- feedback
- opportunity for individual consultation where necessary

## 3.20 Service Evaluation Tool

### **Check if your service is family centred:**

Does your mission statement include family centred values?

Do you have an advisory board-method to include parental representation?

Do all families receive similar information regarding pertinent community services and your team?

Does your service have formal and informal opportunities for parents to meet?

### **Functional goal setting:**

Are there formalised goals setting processes that accommodate individual family needs and changing preferences over time?

Do families and therapist collectively identify therapy goals and families can decide their level of involvement in goal setting?

### **Transition planning:**

Are there clear transition processes and a designated person for transition into and out of service?

Do service members know their program and how it relates/integrates with other services in the community in terms of eligibility availability and the service has a process for sharing this information with all families?

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## Appendix 1: Health Support Survey



### ***Supporting Access to the Early Childhood Care and Education (ECCE) Programme for Children with a Disability***

In 2015 the Department of Children and Youth Affairs (DCYA), Department of Education (DES) and the Department of Health (DoH) established an Interdepartmental group to agree a model to support access to the Early Childhood Care and Education (ECCE) Programme for children with a disability.

This model includes seven levels of support that will enable the full inclusion and meaningful participation of children with disabilities in the ECCE programme. The model progresses from a number of universal supports for all children with a disability (i.e. Levels 1 to 4) to more targeted supports (i.e. Levels 5-7) for children with complex needs arising from a disability.

This survey aims to capture the therapeutic interventions which health care practitioners have offered to mainstream preschools supporting children with disabilities over the past 2 years, including universal supports for all children with disability to targeted supports for individual children.

An opportunity to elaborate on any answer is available at the end of the survey.

The information gathered on existing good models of practice supporting children to access mainstream preschool will be used to inform the development of a national suite for dissemination across the country so your input is invaluable.

This survey should take you no longer than 10 minutes to complete. The level 6 Health Supports Project Team would like to thank you in advance for your participation.

***Can you please complete and return by Friday 13th May 2016***

***1. Please state your name, role, agency and contact details***

***2. Please indicate the LHO area in which your service is located***

- Cavan/Monaghan
- Donegal
- Sligo/Leitrim
- Galway
- Mayo
- Roscommon
- Clare
- Limerick
- Tipperary N.R.
- Kerry
- Cork North
- Cork North Lee
- Cork South Lee
- Cork West
- Carlow/Kilkenny
- Tipperary S.R.
- Waterford
- Wexford
- Dublin South East
- Dublin South
- Wicklow

- Dublin South City
- Dublin South West
- Dublin West
- Kildare/West Wicklow
- Laois/Offaly
- Longford/Westmeath
- Louth
- Meath
- North Dublin
- Dublin North Central
- North West Dublin

**3. Please identify your service type**

- Primary Care
- Early Intervention Service Pre reconfiguration under Progressing Disability Services
- Children's Network Disability Team
- Other (please specify)

**4. Please identify what targeted / universal supports your service provides to children with additional health needs attending preschool (ECCE Programme)**

	<i>Discipline Involved</i>	<i>2nd Discipline Involved</i>
<p><b>Preparation for attending a preschool service e.g. preschool readiness group, individual preparation</b></p>	<div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <p>Preparation for attending a preschool service e.g. preschool readiness group, individual preparation Discipline Involved menu</p>	<div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <p>Preparation for attending a preschool service e.g. preschool readiness group, individual preparation 2nd Discipline Involved menu</p>
<p><b>Preschool visits e.g. before child entered the preschool service/when</b></p>	<div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <p>Preschool visits e.g. before child entered the preschool service/when child entered the preschool service Discipline Involved menu</p>	<div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <p>Preschool visits e.g. before child entered the preschool service/when child entered the preschool service 2nd Discipline Involved menu</p>

	<i>Discipline Involved</i>	<i>2nd Discipline Involved</i>
<i>n child entered the preschool service</i>		
<i>Individualized preschool plan e.g. Individual Education Plan (IEP)</i>	Individualized preschool plan e.g. Individual Education Plan (IEP) Discipline Involved menu	Individualized preschool plan e.g. Individual Education Plan (IEP) 2nd Discipline Involved menu
<i>Telephone support e.g. to the preschool provider, the family of the child</i>	Telephone support e.g. to the preschool provider, the family of the child Discipline Involved menu	Telephone support e.g. to the preschool provider, the family of the child 2nd Discipline Involved menu
<i>Invitation to preschool provider to attend therapy sessions with the child</i>	Invitation to preschool provider to attend therapy sessions with the child Discipline Involved menu	Invitation to preschool provider to attend therapy sessions with the child 2nd Discipline Involved menu
<i>An individual child specific preschool programme</i>	An individual child specific preschool programme Discipline Involved menu	An individual child specific preschool programme 2nd Discipline Involved menu
<i>Preschool visits on request by provider/parent</i>	Preschool visits on request by provider/parent Discipline Involved menu	Preschool visits on request by provider/parent 2nd Discipline Involved menu
<i>Specialised Equipment</i>	Specialised Equipment Discipline Involved menu	Specialised Equipment 2nd Discipline Involved menu
<i>General Information Leaflets</i>	General Information Leaflets Discipline Involved menu	General Information Leaflets 2nd Discipline Involved menu
<i>Open Evenings</i>	Open Evenings Discipline Involved menu	Open Evenings 2nd Discipline Involved menu

	<i>Discipline Involved</i> menu	<i>2nd Discipline Involved</i> menu
<b>Once off talks on specific topics e.g. PECS, Visual Supports, Epilepsy, Asthma, Autism</b>	Once off talks on specific topics e.g. PECS, Visual Supports, Epilepsy, Asthma, Autism Discipline Involved menu	Once off talks on specific topics e.g. PECS, Visual Supports, Epilepsy, Asthma, Autism 2nd Discipline Involved menu
<b>Practical Strategies Workshop e.g. Toileting, Sensory Interventions, Behaviour Management Plans, Behaviour Management Plan</b>	Practical Strategies Workshop e.g. Toileting, Sensory Interventions, Behaviour Management Plan Discipline Involved menu	Practical Strategies Workshop e.g. Toileting, Sensory Interventions, Behaviour Management Plan 2nd Discipline Involved menu
Other, please specify, including any other disciplines involved		

**5. Please identify what training your service delivered to preschools in the last two years. Please include training scheduled for September 2016. The list of examples below is not exhaustive, please include others as required**

	<i>Yes/No</i>	<i>Discipline(s) Involved</i>	<i>Discipline(s) Involved other</i>
<b>Hanen Programme</b>	Hanen Programme Yes/No menu	Hanen Programme Discipline(s) Involved menu	Hanen Programme Discipline(s) Involved other menu
<b>Lámh</b>	Lámh Yes/No menu	Lámh Discipline(s) Involved menu	Lámh Discipline(s) Involved other menu
<b>Makaton</b>	Makaton Yes/No menu	Makaton Discipline(s) Involved menu	Makaton Discipline(s) Involved other menu
<b>Picture Exchange Communicati</b>	Picture Exchange	Picture Exchange Communication System	Picture Exchange Communication System

	<i>Yes/No</i>	<i>Discipline(s) Involved</i>	<i>Discipline(s) Involved other</i>
<b>on System (PECS)</b>	Communication System (PECS) Yes/No menu	(PECS) Discipline(s) Involved menu	(PECS) Discipline(s) Involved other menu
<b>Sensory Integration Training</b>	Sensory Integration Training Yes/No menu	Sensory Integration Training Discipline(s) Involved menu	Sensory Integration Training Discipline(s) Involved other menu
<b>Postural Management/Seating</b>	Postural Management/Seating Yes/No menu	Postural Management/Seating Discipline(s) Involved menu	Postural Management/Seating Discipline(s) Involved other menu
<b>Manual Handling</b>	Manual Handling Yes/No menu	Manual Handling Discipline(s) Involved menu	Manual Handling Discipline(s) Involved other menu
<b>EarlyBird Plus</b>	EarlyBird Plus Yes/No menu	EarlyBird Plus Discipline(s) Involved menu	EarlyBird Plus Discipline(s) Involved other menu
<b>Developmental Individual-Difference Relationship based model (DIR Floortime)</b>	Developmental Individual-Difference Relationship based model (DIR Floortime) Yes/No menu	Developmental Individual-Difference Relationship based model (DIR Floortime) Discipline(s) Involved menu	Developmental Individual-Difference Relationship based model (DIR Floortime) Discipline(s) Involved other menu

Other, please specify, including any other disciplines involved

6. For any of the above, are any other agencies outside of health involved e.g. CCC's

- Yes
- No

If Yes, Please describe briefly

**7. Does your service provide supports to ECCE programme providers for children unknown to health, including those on your waiting list?**

- Yes
- No
- If **yes**, please explain

**8. Please elaborate on the supports your service provides for preschools to enable children with a disability to participate in the ECCE programme and what the impact of these health supports are.**



Done

Appendix 2 : Survey Results			UNIVERSAL SUPPORTS				TARGETED SUPPORTS								EVIDENCED BASED TRAINING							
LIG	Responder	Support to children 'unknown' to service	Leaflets	Open Evenings	Talks	Practical Strategies	Preparation for preschool	Preschool Visits	IEP	Telephone Support	Invitation to therapy session	Individual Preschool Programme	Preschool visit on request	Specialised Equipment	Hanen	Lámh	PECS	Sensory Integration Training	Postural Management /Seating	Manual Handling	EarlyBird Plus	DIR Floortime
Donegal	Preschool Inclusion Coordinator	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	Y
Donegal	EIT Manager	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	N	N	N	N	N	N	N	N
Donegal	SLT manager	N	N	N	Y	N	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	Y
Cavan/Monaghan	Early Services Mgr	N	N	N	Y	Y	N	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	N
Sligo/Leitrim	CHO1 Rep	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Galway	HSE children services coordinator	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mayo	Unidentified	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N
Roscommon	Team Services Leader	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Lim/Clare/Tipp. N.	DOC Principal SW EIT	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y
Lim/Clare/Tipp. N.	Clinical Manager – Limerick	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N
Lim/Clare/Tipp. N.	EIT	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Lim/Clare/Tipp. N.	CNDT Manager	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Lim/Clare/Tipp. N.	CNDT	N	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Kerry	CNDT Manager	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	N	N	N	N
Cork West	CNDT Manager	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N
Cork North Lee	EIT -	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	N	N	Y

Cork South Lee	Clinic Coordinator	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
Cork North	ESM/SLT MGR	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	N
Tipperary South	HSE O/T manager	N	N	N	N	N	N	Y	Y	Y	N	N	N	Y	N	N	N	N	Y	N	N	N
Tipperary South	HSE Physio	N	N	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
Tipperary South	HSE SLT	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N	N	Y	Y	N	N	N	N	Y
Carlow/Kilkenny	Mgr	N	N	N	Y	N	Y	Y	N	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N	N
LIG	Responder	Support to children 'unknown' to service	Leaflets	Open Evenings	Talks	Practical Strategies	Preparation for preschool	Preschool Visits	IEP	Telephone Support	Invitation to therapy session	Individual Preschool Programme	Preschool visit on request	Specialised Equipment	Hanen	Lámh	PECS	Sensory Integration Training	Postural Management /Seating	Manual Handling	EarlyBird Plus	DIR Floortime
Carlow/Kilkenny	HSE - SLT manager	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	Y	Y
Wexford	HSE - SLT manager	N	N	N	N	N	N	Y	Y	Y	N	Y	N	N	N	N	Y	N	N	N	N	N
Wexford	HSE O/T manager	N	Y	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	N	Y	N	Y	Y	N	N
Waterford	HSE -Disability Manager	N	N	N	N	N	Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	N	Y	N
Dublin south/South East	EIS Supervisor	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	N	N	N	N
Dublin south/South East	Principal SW	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N
Dublin south/South East	HSE - EIT Psychologist Manager	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	N	N	Y	N
Dublin south/South East	HSE - EIT Physiotherapist	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	N	N	N	N	N	N	N	N
Dublin South/South East	HSE - EIT - SLT	N	Y	N	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	N	N	N	N

Dublin South/South East	HSE - EIT - OT	N	Y	N	Y	Y	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
Dublin South/South East	HSE - EIT SLT	N	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	N
Wicklow	Services Manager	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
Wicklow		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	N	N	N
Dublin South West	Programme manager	N	N	N	N	N	N	Y	N	Y	Y	Y	Y	N	N	Y	N	N	N	N	N	N
Dublin South West	Education Specialist	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	N	Y	N	N	N
Dublin South West	ESM	N	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y
Dublin South West	Voluntary Agency - Unidentified	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y
Kildare West Wicklow	HSE - Team Manager	N	N	N	Y	Y	Y	N	N	Y	N	N	Y	Y	N	N	Y	N	Y	Y	N	N
LIG	Responder		Leaflets	Open Evenings	Talks	Practical Strategies	Preparation for preschool	Preschool Visits	IEP	Telephone Support	Invitation to therapy session	Individual Preschool Programme	Preschool visit on request	Specialised Equipment	Hanen	Lámh	PECS	Sensory Integration Training	Postural Management /Seating	Manual Handling	EarlyBird Plus	DIR Floortime
Kildare West Wicklow	HSE psychologist	N	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N
Kildare West Wicklow	HSE - Team Manager	N	N	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N
Dublin South Central	HSE - Coordinator	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N
Dublin South Central	HSE SW Team leader -	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	Y	N	N	Y	N

Louth	EIT - Preschool Coordinator + EIT Manager combined	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	N	N	N
Meath	EIT - early Services Manager	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	N	N	N	N	Y	N
Midlands	EIT Clinical Psychologist	N	N	N	Y	Y	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Midlands	EIT OT -	N	N	N	N	Y	N	Y	N	Y	Y	N	Y	Y	N	N	N	N	N	N	N	N	N
Midlands	EIT	N	Y	N	Y	Y	Y	Y	N	Y	N	Y	Y	Y	N	N	N	Y	N	N	N	N	N
Midlands	Psychologist	N	N	N	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	N	N	N	N
Dublin North	Community Nurse	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
Dublin North	Home teacher Manager	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N
Dublin North	HSE - EIS Psychologist	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N	N	N	N	N	N	N
Dublin North	HSE - EIT and PC -	Y	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	N	N	N	N	N	N

