



**Partnering for Change:**

**An Innovative Service with Relevance to the Special  
Needs Strategy**



# **Table of Contents**

<b>Executive Summary .....</b>	<b>2</b>
<b>Acknowledgements .....</b>	<b>3</b>
<b>Introducing Partnering for Change (P4C) .....</b>	<b>4</b>
<b>What Is the Partnering for Change Model? .....</b>	<b>6</b>
<b>What Are the Principles of Partnering for Change? .....</b>	<b>9</b>
<b>What Is the Ontario Special Needs Strategy? .....</b>	<b>11</b>
<b>When Is It Possible to Identify Children with Special Needs? .....</b>	<b>11</b>
<b>Partnering for Change: Complementing the Developmental Screening Process .....</b>	<b>13</b>
<b>How Does Partnering for Change Align with the Special Needs Strategy? .....</b>	<b>14</b>
<b>What Research Supports the Partnering for Change Model? .....</b>	<b>15</b>
<b>Research Findings from Year 1 (Nov 2013- June 2014): .....</b>	<b>16</b>
<b>Learn More: .....</b>	<b>18</b>
<b>APPENDIX: Partnering for Change (French Translation) .....</b>	<b>19</b>

## **Executive Summary**

Ontario's Special Needs Strategy offers an unprecedented opportunity for communities and regions to explore new approaches to delivering integrated rehabilitation services in schools and to consider how health professionals, educators, and families can work together to best serve children with special needs.

**Partnering for Change (P4C)** is an innovative, collaborative school-based service model that is highly relevant to the Special Needs Strategy. Created by researchers at *CanChild* Centre for Childhood Disability Research and supported by the leadership of Cathy Hecimovich, CEO of the Central West Community Care Access Centre (CW CCAC), P4C has been developed and tested using a participatory action research process spanning 8 years. This process involved key stakeholders from government, health care decision-makers, service provider organizations, schools, and families.

The **goals of P4C** include **early identification of children with special needs; promoting everyday functioning and participation in school; preventing secondary consequences; and building capacity within schools and families.** The P4C service model supports capacity building by fostering active collaboration between health professionals and educators, with coaching of educators taking place in the school context. Strategies that enable children to be successful are identified and then shared with parents to help support children at home.

Health professionals provide services within a tiered, response-to-intervention pyramid. This means that services are provided along a continuum so that students with more complex needs receive more focused services; it also means that students' response to services are monitored regularly and adjusted. P4C services include class-wide health promotion and learning designed to help all students; small group screening and differentiated instruction; and individualized accommodations.

Funded by the Ministries of Health and Long Term Care, and Education, the P4C service model is being evaluated in three school boards within two of Ontario's CCACs (Central West and Hamilton Niagara Haldimand Brant). Positive results from the first year of our research led CW CCAC to expand provision of P4C to two additional school boards in their region, demonstrating the potential for this model to spread beyond the current research study.

Results to date indicate that P4C facilitates **equal access to services, eliminates wait lists, and serves large numbers of children with a diverse array of special needs.** Moreover, the many stakeholders involved in the research and implementation of this service model have indicated that the core principles and features of P4C are relevant to all health professionals and educators seeking an integrated framework for rehabilitation service provision in Ontario.

## Acknowledgements

The Partnering for Change Team would like to acknowledge the many stakeholders, occupational therapists, educators, care coordinators, service provider organizations, families and children who have contributed to the research and development of the Partnering for Change model of service.

We are particularly grateful to:

- the Ontario Ministry of Health and Long-term Care for funding the current study
- the Ontario Ministry of Education for funding further evaluation of the service.

We would like to acknowledge:

- the strong partnership of: Central West, Hamilton Niagara Haldimand Brant, and Toronto Central CCACs, who have been instrumental in the success of this project,
- the active involvement of leadership, educators, students and families of the Peel District School Board, the Halton District School Board and the Hamilton Wentworth Catholic District School Board,
- the occupational therapists that provided the service and facilitated the research activities.

The multidisciplinary Partnering for Change team at *CanChild* includes:

- Dr. Cheryl Missiuna, Ph.D., OT Reg. (Ont.): Professor, occupational therapist
- Nancy Pollock, MSc., OT Reg. (Ont.): Associate Clinical Professor, occupational therapist
- Dr. Sheila Bennett, Ed.D.: Professor, special educator
- Dr. Wenonah Campbell, Ph.D., S-LP (C): Assistant Professor
- Dr. Chantal Camden, PhD, PT: Assistant Professor, physiotherapist
- Dr. Robin Gaines, PhD.: Associate Clinical Professor, speech-language pathologist
- Dayle McCauley, MSc.: *CanChild* Research Coordinator
- Dr. John Cairney, PhD.: Professor, epidemiologist
- Dr. Daria O'Reilly: Associate Professor, health economist
- Debra Stewart, MSc., OT Reg. (Ont.): Associate Clinical Professor, occupational therapist
- Leah Dix, MSc., OT Reg. (Ont.): Project Coordinator, occupational therapist
- Cindy DeCola, BA : Project Coordinator
- Sandra Sahagian Whalen, M.H.Sc., OT Reg. (Ont.): Mentor, occupational therapist
- Kathy Wlodarczyk M.Ed.: Doctoral student
- Rhea Makund, BA: Research Assistant

With partnership from key leaders at the Central West (CW), Hamilton Niagara Haldimand Brant (HNHB), and Toronto Central (TC) Community Care Access Centres (CCAC):

- Cathy Hecimovich, CEO, and Kimberley Floyd, Director, Patient Care Services (CW CCAC),
- Melody Miles, CEO, and Dilys Haughton Director, Client Services Operations and Professional Practice Lead (HNHB CCAC),
- Stacey Daub, CEO (TC CCAC).

## **Introducing Partnering for Change (P4C)**

Partnering for Change was initially developed in partnership with leaders from Central West Community Care Access Centre (CCAC), *CanChild*, therapists, school board administrators, policymakers, decision-makers, educators and families to address concerns identified with wait lists for occupational therapy (OT) services.

School-aged children in Ontario who require OT are currently referred to School Health Professional Services; however, in most regions, children, educators and families must endure a significant wait for service. Although wait-times vary across regions, some children wait years before receiving any supports. Even when children do see an OT for treatment, the 1:1 intervention offered is neither sufficient nor appropriate to address their needs, nor is it well integrated into the school context. By the time children actually receive rehabilitation services, their needs have become much more complex than if they had received services earlier.

A 2010 Tri-Ministerial Review of Ontario's School Health Support Services confirmed challenges existed as a result of waitlists for OT services (Deloitte, 2010).

Partnering for Change (P4C) is **an innovative, collaborative, evidence-informed rehabilitation service model** that is aligned with the recommendations of the Deloitte report (Deloitte, 2010). It **eliminates wait-times** while promoting **integrated, needs-based care** for children with special needs in Ontario.

The **goals of Partnering for Change** are to:

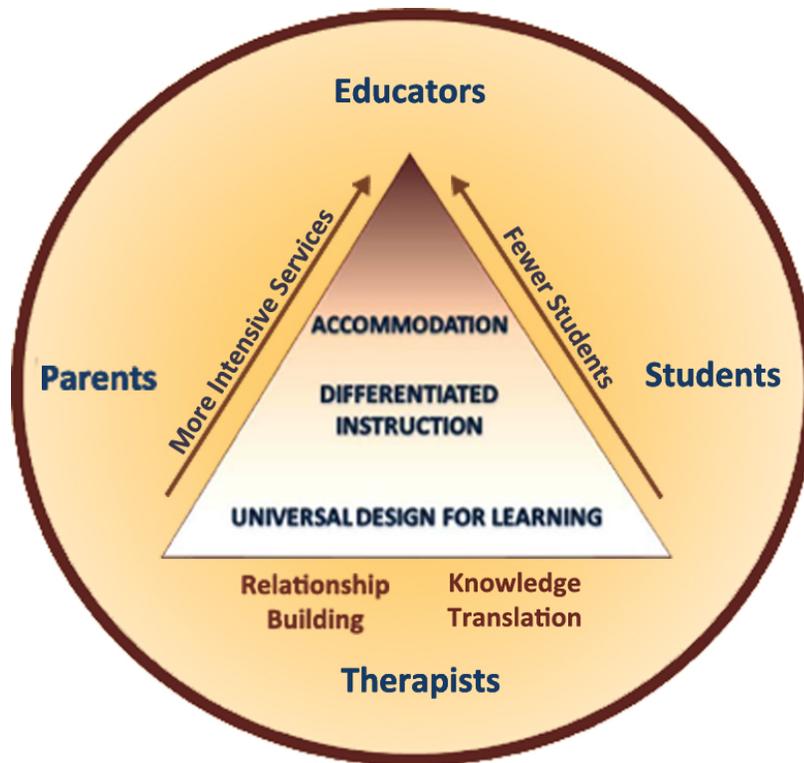
- **increase early identification** of children with special needs,
- **build capacity** of educators and families to manage children's challenges, at school and at home,
- **prevent** secondary developmental, academic and health problems,
- **promote health, well-being and successful participation.**

Partnering for Change reflects the partnerships that have been forged to change outcomes for children with special needs. It is the name of both the service model and the program of research evaluating its implementation.

The acronym P4C also highlights the principles of the model:

# **PARTNERING FOR CHANGE: P4C**

**Building Capacity through Collaboration and Coaching in Context**

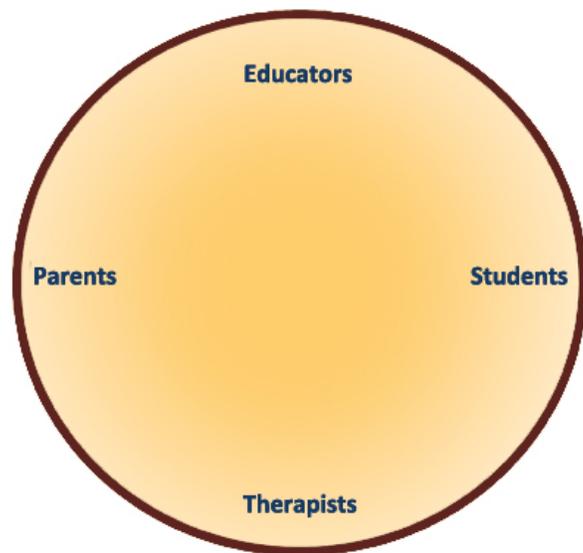


© Missiuna, Pollock, Campbell, Levac and Whalen, *CanChild*, McMaster University, 2011

*Please see the Appendix for the French Translation of the Partnering for Change Model.*

## What Is the Partnering for Change Model?

### Layer 1:

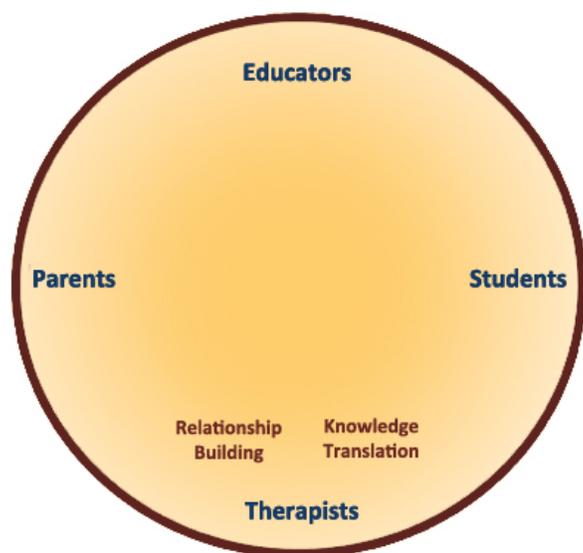


Partnering for Change is the name of an innovative model for **delivering integrated rehabilitation services** to children in schools, beginning in Junior Kindergarten. Called P4C for short, the circle reflects a partnership between educators, therapists, parents, and students who work together to support children's participation at school and at home. By wrapping services around the student from the point of school entry, P4C aims to prevent more complex health and academic issues from developing.

The model embraces what we call the "4 C's": Building **Capacity** through **Collaboration** and **Coaching** in **Context**. In other words, the P4C model aims to build the capacity of educators and parents to support children with special needs in all spaces and places. In the P4C model, therapists do this by **Collaborating** with

educators and families and **Coaching** in **Contexts** that are important to the child – whether that be in the classroom, on the playground, in the gym or at home.

### Layer 2:



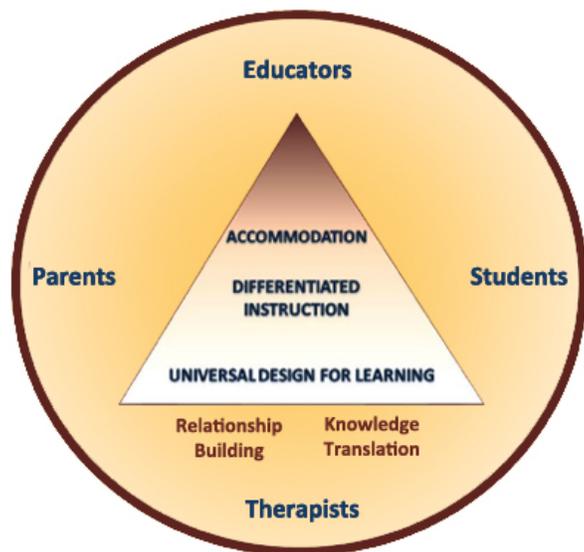
Two Core Activities form the foundation for all other intervention services that are offered within the P4C model.

The first is **Relationship Building** – our research shows that the therapist needs to be a regular and consistent presence in the school, available and seeking opportunities to connect with educators and parents. He or she is responsive to the school's needs; services are provided to students in the right place at the right time and follow up is regular and timely.

The other Core Activity is **Knowledge Translation** – this means the health professional needs to be able to provide evidence-based information about how to support students' participation in a way that educators can use in the classroom and that a parent can use at home. The goal of Knowledge Translation

is to build the capacity of others by problem-solving together, identifying and demonstrating strategies that enable successful student participation and then explaining how, why, and when particular strategies work. Educators and families can then apply these strategies when appropriate and adapt this knowledge in their day-to-day activities.

### Layer 3:



**PARTNERING FOR CHANGE: P4C**  
Building Capacity through Collaboration and Coaching in Context

The types of services included in the P4C model are based on a **Response to Intervention pyramid** where services are provided universally to support all children in a classroom, with increasingly intensive services being added for children whose needs are not able to be met through class-wide strategies.

Three types of tiered services are included inside the pyramid: Universal Design for Learning; Differentiated Instruction; and Individualized Accommodations.

**1. Universal Design for Learning (UDL):** These are strategies that are “good for all and essential for some”; for example, helping educators to identify the motor demands of curriculum tasks, or to learn how to use

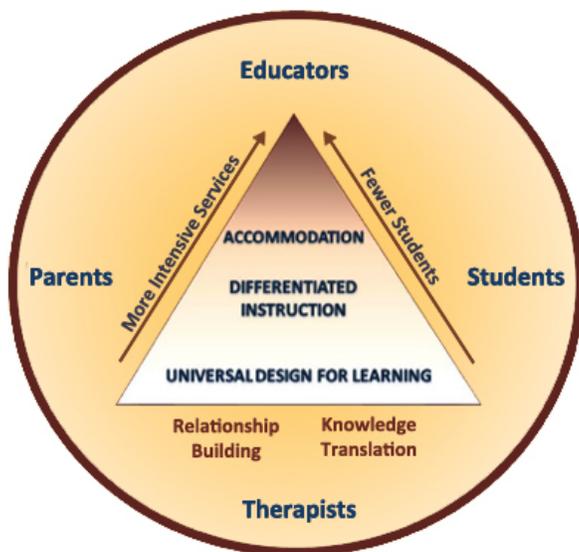
non-motor based strategies, such as verbal instructions, to help students learn new motor skills. Therapists may collaborate with the educator on increasing the physical accessibility of their classroom; helping to design activity centres that promote sensory, cognitive, and motor development; or teaching large group lessons that model ways to support students – whether that is in the students’ development of self-regulation strategies, self-help skills such as dressing or managing backpacks, developing specific skills required for participation in academic activities including scissor cutting, printing, copying from the board, using a ruler or drawing; or encouraging children to give visual attention to the teacher and to rehearse or paraphrase instructions to ensure that they understand it.

**2. Differentiated Instruction:** Here, the therapist and educator begin to look at smaller groups of students who are having difficulty performing grade-level activities despite exposure to class-wide strategies at the UDL tier. Different educational practices are tried to target individual student needs; for example, determining if additional visual cues are needed to support sequencing of putting clothes on, or to help children follow step-by-step auditory instructions. They also begin to differentiate those students who are having trouble due to lack of experience from students who may have more specific developmental needs. For example, a child who is having difficulties using scissors may not have used them at home and may need extra instruction and opportunity to practice in order to acquire that skill; conversely, another child may not benefit from practice and

might need more direct teaching or the option to use different types of scissors. Alternatively, another student may require specific accommodations so s/he was not required to cut and would therefore require additional support at the third tier.

**3. Accommodation:** At the top of the pyramid there is a focus on individual students who have more complex needs. The therapist conducts observational assessment in context – wherever the issue is occurring. This process is called dynamic performance analysis, which means that the therapist tries implementing specific strategies involving a change in the task or environment; the child’s response is monitored, and the outcome of the change is determined. If the strategy was not successful, something else is trialed. An important component in P4C is that therapists then communicate with the educator/parent/team about what was done, and why, to build capacity through knowledge translation. Students receiving this level of support may require access to technology or accommodations during class activities. For example, some students who have low muscle tone and postural instability are unable to sit without support; positioning these students so that they can lean against a wall or bookcase during circle time is a simple strategy that eliminates the need to lean on peers. Other students who have trouble focusing attention may be positioned so they can see the teacher’s face when she is giving instructions or be given the opportunity to work at a station where they can stand instead of being seated when they are fidgety; still others may require adaptations to their seat or desk to maximize their stability. In all cases, families are aware of the issue and have consented to have these strategies and accommodations put in place.

**Layer 4:**



In the final layer of the P4C model, we have added arrows at the sides of the Response to Intervention pyramid. These arrows show that as the intensity of the P4C service increases, the number of students needing services at that level simultaneously decreases.

By using a tiered approach, the P4C model enables many diverse student needs to be met by ensuring that the level of support is needs-based and reaches all students – from those who need only classroom-wide supports to those who need customized strategies to maximize their potential.

**PARTNERING FOR CHANGE: P4C**  
Building Capacity through Collaboration and Coaching in Context

## What Are the Principles of Partnering for Change?

Five principles define P4C and highlight the difference between this model and other rehabilitation service models. These are: partnering, capacity building, collaboration, coaching and context.

### **Partnering:**

P4C is a **needs-based model** that emphasizes the **partnership** between the rehabilitation service provider, educators, families and relevant service coordinators.

### **Capacity building:**

The P4C service is focused on **building parent and educator capacity** so that all can increasingly support both a specific child, and other children in need.

The prevalence of children with the types of challenges that are evident at school age is very high: there are at least two or three children with special needs in every classroom. Educators are supported in learning how to recognize children with atypical development and special needs earlier so that strategies can be used to **reduce the development of secondary consequences**.

Knowledge is shared with educators to:

- facilitate their ability to identify children who have atypical development that suggests a health concern
- enable **job-embedded learning and best practices in educator professional development**
- **build capacity in Universal Design for Learning (UDL) and Differentiated Instruction;** which will lead to **more inclusive practice for all children including those with special needs.**

Knowledge is shared with families to:

- facilitate their **understanding of their child's needs**
- enable **learning** about their child's health/developmental concern
- support **introduction and generalization of strategies** that have been found to be successful at school or at home
- **build families' capacity** to advocate for their child and **self-manage** their child's special needs to prevent the development of secondary consequences.

Occupational therapists are also building their own capacity to work successfully in this type of service model.

## Collaboration:

In P4C, the health professional is in the school on a very regular basis to **collaborate with educators** and to be available to parents when the child needs more support. Educators and therapists work together to ensure that children and youth receive the appropriate level of service to meet their evolving needs and changing school and home demands. Therapists support educators directly **in the classroom**, when invited to do so by the educator.

Partnering for Change therapists collaborate with educators to:

- **prevent developmental and motor challenges** from becoming greater issues for the student and classroom (e.g., prevention of depression, anxiety, behavioural problems, deterioration in physical fitness, social isolation, school avoidance, bullying),
- **promote emotional well-being,**
- enable **timely** and **efficient** determination of accommodations that are required to maximize participation,
- identify individual students' needs and accommodations to fully demonstrate students' potential on tests and assessments including EQAO (e.g., provision of technology).

The P4C therapist and educator collaborate as they:

- use differentiated instruction to identify student challenges early **without** the need for **formal identification of exceptionality.**
- **engage families.** Families are valued partners and can connect with both the educator and P4C therapist when and as needs arise for the student. This enables the family to self-refer without waiting to be referred for service, eliminating wait times and complex paperwork.

## Coaching:

The therapist is fully integrated into the classroom and school using **coaching** as a specific approach to interacting. Coaching means that the therapist determines what the educator and parent already know and builds on those skills by collaboratively problem solving the reasons for the child's difficulties, the rationale for trying the suggested strategies, modelling the strategies, supporting their application and generalization; and monitoring regularly to ensure that strategies are still working.

## In Context:

All aspects of the model build the capacity of the adults who are in the child's daily environment, in the classroom and throughout the school, where the child spends a significant portion of each day. Dynamic assessment and observation occurs wherever the child is during the day; children are not taken out for standardized assessment or individual therapy. P4C alleviates the concerns of educators trying to manage children with special needs by integrating the health professional into the school environment.

## **What Is the Ontario Special Needs Strategy?**

The Ministries of Children and Youth Services (MCYS), Community and Social Services (MCSS), Education (MEDU), and Ministry of Health and Long-Term Care (MOHLTC) are collaborating to develop a Special Needs Strategy that ensures children and youth with special needs receive timely and effective services from birth to the end of their schooling.

One of the first activities planned within the Special Needs Strategy is research to enable the development and testing of a new standard developmental screening process for children 0-6 years. Dr. John Cairney and colleagues at McMaster University are leading this initiative (<http://inchlab.ca>). The purpose of this work is to support healthy child development and enable earlier identification of children with delay, or children who are at risk, in the early years. This process is expected to enable repeated “temperature taking” so that children’s developmental progress in all areas can be assessed multiple times for determination of supports that are required in response to child and family needs.

Partnering for Change aligns well with this new provincial approach to screening. Both initiatives are evidence-informed and based on strong understanding of child development. Partnering for Change and the new developmental screening process aim to support all children and are designed so that children with the greatest needs receive the support they require.

The Special Needs Strategy also highlights the development of integrated approaches to the delivery of rehabilitation services in school settings that result in a more seamless experience for families and children with special needs. This is where Partnering for Change best aligns with the Special Needs Strategy.

## **When Is It Possible to Identify Children with Special Needs?**

When considering the Developmental Screening Process and the early identification that is facilitated by Partnering for Change, one needs to acknowledge the earliest age at which it is possible to identify children with different types of special challenges and the intensity of needs that they, and their families, are likely to have.

Tables 1 and 2 provide a simplified description of the types of developmental and/or health conditions that might be able to be identified at different ages and stages of development. The prevalence rates are approximate and are intended to provide general guidelines only.

**Table 1: Children who are able to be identified prior to school entry**

Age (at which we can identify)	Examples of Children's Developmental Conditions/Special Needs	Prevalence (approximate)	Need for Rehabilitation or Healthcare Services
<b>Group 1</b> At or near birth	Very preterm infants, medically-fragile, technologically-dependent, severe cerebral palsy, spinal muscular atrophy, complex medical and developmental comorbidities.	Very low (<1%)	High, diverse and continuing throughout lifespan. Often require coordination of care.
<b>Group 2</b> 0 to 3 years	Cerebral palsy, spina bifida, autism, medical and genetic syndromes.	Low (2-3%)	Initially medium-to-high for family support, then low; periodic need for specialized services.
<b>Group 3</b> 1 to 4 years*	Specific language impairment, intellectual delay, high-functioning autism, motor delays, fetal alcohol syndrome, psycho-social or socio-economic circumstances that are not facilitating cognitive, motor, language or social/emotional development.	Not yet known: <b>Developmental Screening Process</b> will target the identification of children in this group.	Initially medium, to support families, then low, IF children are identified.  <i>(children with these types of conditions might also be identified to P4C therapists upon kindergarten entry)</i>

Children who are able to be identified at or near birth may have very high medical needs (**Group 1**) and may be more appropriately served by a different model.

Children who have special needs such as those described in **Groups 2 and 3** may benefit from provision of P4C but this should be demonstrated through further research.

Children with some types of developmental and health concerns may not be able to be identified prior to school entry. Research findings suggest that the P4C service is appropriate to facilitate early identification of the children who have the types of developmental conditions and special needs listed below in Table 2. In the P4C model, therapists are able to work with educators and parents to identify these children and to problem-solve and implement strategies that support their participation in the classroom.

**Table 2: Children who can be identified after school entry using the P4C model**

Age at which we can identify	Examples of Children’s Developmental Conditions/Special Needs	Prevalence (approximate)	Need for Rehabilitation and/or Healthcare Services	Is there evidence for P4C?
<b>JK/SK to Grade 3</b>	Developmental Coordination Disorder, Attention Deficit Hyperactivity Disorder, Specific language impairments, High functioning Autism, Asperger Syndrome, Intellectual Delay, Sensory Issues, Acquired Brain Injury	>10-15%	Initially medium, then low and occasional, <b>IF identified</b>	<b>YES</b>
<b>Grades 4 to 8</b>	Secondary consequences of above, if not recognized – Anxiety, Depression, Low Self-Esteem, Social/Behavioural Issues, Learning Disabilities, Decreased Academic Achievement, Overweight/Obesity	Prevalence, as above but children have more issues	<b>Increasingly complex, if not identified early</b>	<b>YES</b>

**Partnering for Change: Complementing the Developmental Screening Process**

One of the purposes of the Developmental Screening Process is to screen all children many times when they are young. Different types of developmental needs (physical, psycho/emotional, social, communicative, and cognitive) can be picked up at different points in time.

The P4C model of service enables provision of support to full-day kindergarten and primary grades to help educators and Early Childhood Educators build knowledge and skills regarding typical and atypical development and to manage expectations of children who are at different developmental stages.

P4C therapists introduce universal design for learning strategies that support all children, including children whose “developmental temperature” is raised simply by the **transition** to full day kindergarten.

P4C therapists contribute the eyes and knowledge of a health professional within the school environment. When a child is identified as struggling, P4C involves engagement with parents and educators to build capacity and support optimal development.

## **In the Proposed Developmental Screen and in P4C:**

- screening is being done in a convenient location for families
- decision-making takes place over time to enable monitoring of “response to intervention”
- relationship building and knowledge exchange with families are valued as core components
- regular interactions afford opportunity to educate families and to connect them to resources.

## **How Does Partnering for Change Align with the Special Needs Strategy?**

The inequity currently occurring across Ontario pertains to access to rehabilitation services: wait-times for service can be lengthy; some parents choose to pay privately for rehabilitation services; and many children with special needs are unrecognized and fall through the cracks. P4C provides **more equitable access** because the therapist:

- is the point of first contact, which **negates** the need for **lengthy and resource-intensive referral mechanisms** before the child is able to receive support,
- works with educators and whole classrooms of students in schools, providing support that **increases all children’s participation and achievement,**
- observes children **in the classroom context** to support those who are struggling
- works with small groups of children, tries out **simple strategies,** then **monitors the response to the intervention,**
- determines whether a child needs more individualized health care or rehabilitation services. If so, it is still provided in the school context in collaboration with educators and families, **eliminating waitlists.** The model enables flexibility and opportunities for care planning to ensure children’s needs are being met.

Thus, P4C incorporates **health promotion** that permits informal developmental screening of all children for developmental and learning needs. It **eliminates the need for diagnosis** of health care conditions or formal psycho-educational assessments before supports are able to be put in place.

P4C moves away from 1:1 services that are focused on remediation of deficits and offers a health service that is **needs-based,** focused on **participation,** consistent with **evidence-informed** practice and that can be **integrated into care plans** for children with special needs. The **needs-based** service enables support to be provided for children when most needed, including at times of transition, such as moving to middle or high school. Our research also shows that Partnering for Change is reaching more children and is more efficient than a 1:1 approach.

## What Research Supports the Partnering for Change Model?

The Partnering for Change model was first developed by *CanChild* researchers, leaders from the Central West CCAC, and other stakeholders to address the inequity and escalating needs of children with Developmental Coordination Disorder (DCD) who represented a majority of the students waiting for OT service.



A number of studies have informed the development of P4C:

- a Pilot project funded by the Ontario Neurotrauma Foundation (2008-2009)
- a Demonstration project funded by the Canadian Institutes of Health Research (2009-2011)
- a Knowledge Translation project funded by the Canadian Institutes of Health Research (2011-2012)
- the current Implementation and Formative Evaluation study funded by the Ontario Ministry of Health and Long Term Care (2013-2015)
- the Summative Evaluation study funded by the Ministry of Education (2015).

In the current MOHLTC-funded study:

- P4C services are provided and **being evaluated** in **40 schools** across **3 school boards**
- OT health services are provided by 2 Community Care Access Centres [Central West (CW), and Hamilton Niagara Haldimand Brant (HNHB)]
- in the 2014-2015 school year, Central West CCAC expanded the service to 20 additional schools
- Thus, P4C is now being offered in **60 schools** across **5 school boards**.

**This demonstrates the responsiveness of the service model to local school environments, cultures and contexts.**

Evidence being collected in the current research project, over **2 school years**, includes:

- an in-depth study of **392 of the 592 children receiving P4C services** comprising both **educator and parent pre- and post-standardized measures** including: the School Function Assessment (SFA), Child and Family Demographics, DCD-Questionnaire, Strengths and Difficulties Questionnaire, Knowledge Questionnaires, Participation and Environment Measure

- completion of an **Educator Knowledge, Skill and Experience Questionnaire** by educators **at the 40 research schools** at 4 different time points to capture educators' acquisition of knowledge about identifying children who have motor delays and their ability to use the information to problem-solve and encourage students' participation in the classroom
- evaluation of the OTs' experiences via focus groups and completion of the **OT Knowledge, Skills and Experience Questionnaire** at 4 time points
- completion of an electronic **OT Daily Log** to record activities at all levels of the P4C pyramid and to describe children with special needs who are able to be served with the P4C model
- data collection at multiple levels within the CCACs regarding **health system change, value for money, integration of the service approach** and **access to timely care**.

**Qualitative interviews** were completed with key stakeholders including 14 school board managers, principals, and special educators; 12 health care coordinators and managers; 5 OTs and 3 research team members after Year 1. Focus groups also were completed with all OTs in Year 1. Additional interviews and focus groups are taking place in the spring of 2015.

Research to date has shown that this new model is relevant for children who have significant daily motor, self-care, and academic challenges. CCAC, school board stakeholders, and the OTs in the current study report that it is essential and realistic to offer P4C to all children with special needs. Indeed, its needs-based approach is consistent with best practice for integrated and coordinated health care and rehabilitation services in schools.

### **Research Findings from Year 1 (Nov 2013- June 2014):**

**Waitlists were eliminated** in schools that received P4C. Educators, parents and therapists preferred this model.

The 15 **OTs who provided the P4C service** one day/week in 40 schools provided:

- 3,329 individualized strategies and accommodations for 592 children with special needs and shared that knowledge with educators and families
- 2980 opportunities to screen small groups of children who were having difficulty and to trial differentiated instruction and share findings with educators
- 704 activities at a whole class level, modelling strategies for inclusive education; reaching over 17,600 children
- 385 educator in-services (formal and informal) to build capacity.

## Interviews with Stakeholders in Year 1:

- CCACs and School Boards commented on **earlier identification** of children, moving children off CCAC waitlists, and having children seen sooner than in the traditional model.

*“You see the kids sooner, you can make recommendations, corrections so down the road they won’t need you... These children are getting seen in the appropriate place at the appropriate time.” (CCAC)*

- Principals cited **high satisfaction** with this model of service and offered strong support for the collaborative learning that occurred; how helpful it was to have an OT as part of the school team to enable problem solving quickly without formal referral or the constraint of student diagnoses. One principal said:

*“... instead of waiting for suggestions for 18 months or whatever, we can get answers and we can get assistance with that right away... and the child feels better with their self-esteem because they are getting help to fix something before it becomes a much bigger problem” (principal in a school board that does not employ OTs)*

- All stakeholders perceived P4C to be an **effective** service model for fostering participation of children with DCD and **recommended that it is useful for other children with other types of special needs** as well.

A grant from the Ontario Ministry of Education enables data collection to continue to the end of the 2014-15 school year. Results will be available to be presented to all Ministries by early fall 2015.

## In summary, Partnering for Change:

- promotes **early identification** followed by modification of the physical and social learning environments to include all children with special needs
- permits support and knowledge to be exchanged **collaboratively** and **in context** to allow educators to design educational activities, instruction, resources, and environments that enable **all children to participate, be included and be successful**
- targets children’s participation in the classroom and at home with parents, educators, the child, and health care providers working collaboratively to **build** the child’s **skills, confidence, and physical, social and emotional wellbeing**
- offers timely support to **prevent health consequences** that can build when challenges persist unaddressed.

Working in partnership, scientists from *CanChild* Centre for Childhood Disability Research and leaders from Central West Community Care Access Centre have systematically developed, pilot tested, implemented, and are now evaluating an innovative integrated approach for occupational therapy services in school settings. The **Partnering for Change model eliminates waitlists and**

**fills most of the gaps that existed in service provision.** Moreover, the principles of the model are relevant to other rehabilitation professionals who provide services to school-age children.

Now being tested in 60 schools in 5 school boards, **P4C is demonstrating the success that is possible when educators and rehabilitation professionals work collaboratively to support the participation of children with special needs.**

### **Learn More:**

**<http://dcd.canchild.ca/en/>**

Missiuna, C., Pollock, N., Levac, D., Campbell, W., Sahagian Whalen, S., Bennett, S., Hecimovich, C., Cairney, J., & Russell, D. (2012). Partnering for Change: An innovative school-based occupational therapy service delivery model for children with developmental coordination disorder. *Canadian Journal of Occupational Therapy, 79*, 41-50.

Missiuna, C., Pollock, N., Campbell, W., Bennett, S., Hecimovich, C., Gaines, R., DeCola, C., Cairney, J., Russell, D., & Molinaro, E. (2012). Use of the Medical Research Council Framework to develop a complex intervention in pediatric occupational therapy: Assessing feasibility. *Research in Developmental Disabilities, 33*, 1443-1452.

Campbell, W., Missiuna, C., Rivard, L., & Pollock, N. (2012). "Support for Everyone": Experiences of occupational therapists delivering a new model of school-based services. *Canadian Journal of Occupational Therapy, 79*, 51-59.

### **FOR MORE INFORMATION ABOUT PARTNERING FOR CHANGE:**

Leah Dix, Project Coordinator  
Phone: 905-525-9140 x 26896 [dixlm@mcmaster.ca](mailto:dixlm@mcmaster.ca)

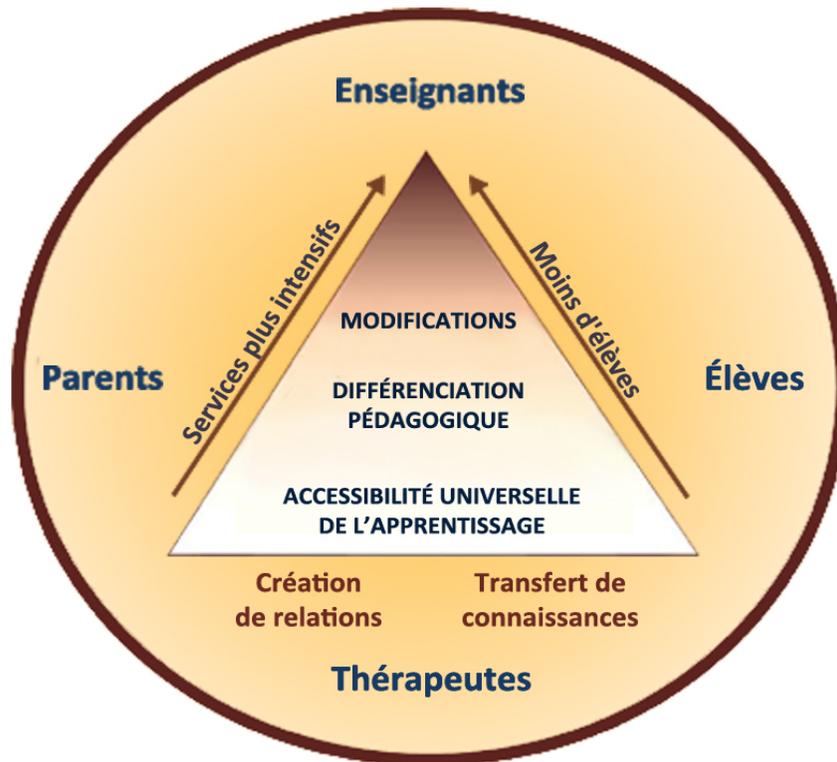
Dr. Cheryl Missiuna, PhD  
*CanChild* Centre for Childhood Disability  
Research  
School of Rehabilitation Science,  
McMaster University  
[missiuna@mcmaster.ca](mailto:missiuna@mcmaster.ca)

Dr. Wenonah Campbell, PhD  
*CanChild* Centre for Childhood Disability  
Research  
School of Rehabilitation Science,  
McMaster University  
[campbelw@mcmaster.ca](mailto:campbelw@mcmaster.ca)

Cathy Hecimovich, Chief Executive Officer  
Kimberley Floyd, Director, Patient Care Services  
Central West Community Care Access Centre  
[Kimberley.Floyd@cw.ccac-ont.ca](mailto:Kimberley.Floyd@cw.ccac-ont.ca)

Professor Debra Stewart  
*CanChild* Centre for Childhood Disability  
Research  
School of Rehabilitation Science,  
McMaster University  
[stewartd@mcmaster.ca](mailto:stewartd@mcmaster.ca)

## APPENDIX: Partnering for Change (French Translation)



### **PARTENAIRES POUR LE CHANGEMENT: P4C** Développement de Capacités via la Collaboration et le Coaching en Contexte

© Missiuna, Pollock, Campbell, Levac and Whalen, *CanChild*, McMaster University, 2011

L'équipe de [Partnering for Change](#) (Partenaires pour le changement – P4C) a utilisé les données probantes afin de développer un modèle conceptuel. Ce modèle, testé en milieu scolaire et raffiné par la suite, est illustré à la figure ci-haut. La figure met en lumière le partenariat qui est nécessaire entre les **thérapeutes**, les **parents** et les **enseignants** afin de créer des environnements qui faciliteront la participation de **tous les élèves**. À la base, il est important de prendre le temps de **développer des relations** entre ces partenaires et de favoriser le **transfert des connaissances**. Ensemble, les partenaires collaborent à la **création d'environnements** qui favorisent le développement des habiletés des enfants, les **instructions différenciées** pour les enfants qui ont des difficultés et **l'accommodation** pour les élèves qui ont besoin de participer différemment. L'école demeure le centre de l'intervention, ce qui permet aux thérapeutes d'avoir un impact sur un grand nombre d'enfants. Le coaching aux enseignants et parents permet aux thérapeutes d'offrir une intensité de services plus élevée aux enfants qui ont des besoins plus complexes. Dans ce modèle, la collaboration et les interventions se déroulent dans l'environnement scolaire.