Team collaboration in Dutch paediatric rehabilitation. Cooperation between parents, rehabilitation professionals and special education professionals in the care for children with cerebral palsy
Nijhuis, Bianca Gertruda Johanna

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2007

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.
8.1 RATIONALE OF THE RESEARCH PROJECT

The view that in the care delivery and education of children with cerebral palsy (CP) or other transient or permanent disabilities close collaboration among the parents, children and professionals is indispensable has become well-established both in the literature and in the clinical practice (Bakheit, 1996; Hinojosa et al., 2001; Robards, 1994; Rosen et al., 1998; Thylefors et al., 2000; Yerbury, 1997). Theoretical principles have been exhaustively described and various approaches to team collaboration, including multi-, inter- and transdisciplinary models, have been proposed (Bailey et al., 1992; Bakheit, 1996; Barnes & Turner, 2001; Hinojosa et al., 2001; Larsson, 2000; Thylefors et al., 2000). Notwithstanding the long history of the discussions and the extensive body of literature explaining and corroborating “the need for team collaboration”, there is some urgency in the need for a definitive explication of the concept: What does team collaboration in paediatric rehabilitation actually encompass? Moreover, the diversely composed multidisciplinary teams need guidance in applying the proposed principles, which accordingly requires methodical directives that help team members put the collaborative approaches into practice. Finally, as a consequence of the current lack of insight, evaluative tools that can accurately measure the effectiveness of team collaboration practices are lacking and we do need such tools to investigate how different approaches and procedures affect client (i.e. child and family) satisfaction, costs and functional status. In sum, team collaboration is endorsed but whether, why and in which manner it is effective we do not truly know.

It is evident that systematic research investigating how teams should collaborate, how collaborative practices can be evaluated and how changes in specific elements of the collaboration process affect the rehabilitation outcome is crucial. We need a) “working protocols” that are based on the existing theoretical foundations and tuned to the unique characteristics of the client and the environment in which the collaboration takes place and b) valid assessment tools that help describe and evaluate current practices and outcomes, allowing close, continuous monitoring of the quality and efficacy of the care provided and thus facilitating the ongoing pursuit of qualitative improvements.

The purpose of the studies presented in the current thesis hence was to explicate the concept of team collaboration, to capture the organisational characteristics of teamwork in Dutch paediatric rehabilitation and to describe the manner in which parents, rehabilitation professionals and special education professionals currently work together.

8.2 SUMMARY AND IMPLICATIONS OF THE MAIN FINDINGS

We feel the results of our studies have contributed threefold to the charting and hence hopefully to the future enhancement of the collaboration among parents, rehabilitation professionals and special education professionals in paediatric rehabilitation in the Netherlands.

First, by explicating the complex process of team collaboration and by identifying the most salient elements based on a detailed review of the literature (Chapter 2), we have made the collaboration process quantifiable, allowing current practices to be described and evaluated. The six key features of team collaboration - communication, decision making, goal setting, organization, team process and parent involvement - and the 29 salient elements we identified can serve as the basis for the development of working protocols. Currently, such practical guidelines on team collaboration at the institutional level are lacking (Chapter 3), which hampers the collaboration among the
parents, the rehabilitation centres and schools for special education. There is a strong need for the translation of commitments to collaborate into transparent protocols defining team procedures and guaranteeing a true and equal involvement of all parties concerned. It is expected that working protocols will significantly facilitate the delivery, assessment, adjustment and improvement of coordinated care.

Second, in addition to the presented findings, the data-collection tools and analytic strategies we have employed for our investigations provide the field of paediatric rehabilitation with new tools to evaluate (parts of) the team collaboration process (Chapters 2, 4, 5, 6 and 7). As suggested in Chapter 2, the key features and core elements identified in our review can be utilised as a general checklist in the description of current collaborative practices.

Completed for each child and family, the Measure of Processes of Care for Service Providers (MPOC-SP) enables the teams to evaluate whether the care they provide is sufficiently family-centred (Chapter 5). Such family-specific evaluations are crucial given that the data reported in Chapter 4 showed that the use of group means for the parental MPOC and the generalised MPOC-SP can obscure considerable differences between the perceptions of the child’s family and those of the rehabilitation- and special education professionals. The addition of importance scales to the MPOC and the family-specific MPOC-SP affords those working in paediatric care an accurate measure of family-centred care (FCC) that acknowledges the uniqueness of the children and their families and allows for their respective preferences and needs. These additional scales make it possible to link the occurrence of behaviours to the weight specific families attribute to these behaviours, thus allowing professionals and researchers to determine whether the parents receive the care they find important.

Moreover, the International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) proved very useful in our cataloguing and analysis of the content of the needs, problems and goals as formulated in the centre’s treatment plans (rehabilitation profiles) for the children with CP. We found that the ICF-CY can not only be used to evaluate the content and relevance of treatments plans, but also to determine whether the needs, problems and treatment goals of the children concur (Chapters 6 and 7).

The third contribution of our studies into team collaboration in Dutch paediatric rehabilitation is the new insights they have generated into current practices and the subsequent identification of areas for improvements.

In our analysis of the current state of affairs in five regional rehabilitation venues we focused on three themes, i.e. the organisation of team collaboration, the family-centredness of the care provided and the goal-setting procedures applied. As mentioned, with regard to the organisation of the collaboration, to date working protocols are lacking and their development is strongly recommended.

As to the family-centredness of the services, we found that families differed considerably in what they deemed important and, more importantly, so did the parents, the rehabilitation professionals and the special education professionals within the same team (Chapter 4). Moreover, despite the fact that policy makers and professionals explicitly endorse FCC, we had to conclude that a considerable number of parents did not receive the care they rated as important.

The results on the goal-setting procedures in use, reported in Chapters 6 and 7, showed that the Rehabilitation Activities Profile for Children (Children’s RAP) is the standard to formulate
interdisciplinary paediatric treatment plans. However, the profiles of the children we examined did not (fully) satisfy the basic requisites and quality criteria as prescribed in the Children's RAP manual, restricting the effective use of this communication instrument. The documentation of the child's and parental needs, problems and goals was not optimal and the treatment plans also failed to provide information on whether parents and the other team members had set priorities or reached consensus on what the most important needs, problems and goals were. Consequently, we found it difficult to objectify the degree to which the needs and problems were integrated into the treatment goals.

8.3 Methodological Reflections

The descriptive methods we used to analyse collaboration in paediatric rehabilitation teams have helped deepen our understanding of how team members currently work together, have revealed more sophisticated ways to evaluate collaborative practices and identified areas for improvement. Due to the descriptive nature of our studies we were unable to investigate causal relationships between collaborative practices and progress or outcome. Given the existing lack of insight into what team collaboration actually is and given the lack of viable methods to assess the process, an empirical study of the effectiveness of team collaboration practices was “one bridge too far” for this thesis. With the present results we feel we have provided a solid basis for future effect studies. Our inventory has resulted in a (check)list detailing essential elements and core features of collaboration, making a description of current practices possible, and reliable assessment tools have been proposed, both facilitating future evaluations of paediatric services, team procedures and treatment outcome.

The choice of written sources and documentary analyses (comprising policy documents, questionnaires, treatment plans) as the paradigm for the studies described in Chapters 3, 6 and 7 of course had its drawbacks, because “practices on paper”, i.e. the documentation and interpretation of actual activities, behaviour and performance, are likely to lag behind and may misrepresent “actual practices”. Nevertheless, our paper-based inventory was essential as we needed to collect valid, consistent clues for future systematic, real-time observations and their analyses in the clinical practice.

One should furthermore keep in mind that self-evaluation instruments, i.e. the MPOC and the family-specific MPOC-SP we used in Chapters 4 and 5, carry the risk that respondents reflect, consciously or unconsciously, on desired behaviour instead of actual behaviour. By incorporating the perspectives of all those involved in the evaluation, we can get a more reliable, objective picture.

In our studies we examined the data of 44 children with cerebral palsy and services were delivered by 83 professionals associated with one of the five regional paediatric centres and 89 professionals working at the affiliated schools for special education. All were involved in the treatment of one or more children and together they represented 11 disciplines. Due to its complex patterns of variability, this data structure restricted the scope of our statistical analyses. Nested sources of variability were present: professionals working in paediatric settings, professionals with different disciplinary backgrounds, settings with different organisational structures, and team members in child-specific teams. In the regular statistical analyses of such data, it is usually illuminating to take account of the variability associated with each level of nesting. One approach to nested data is multilevel analysis, which includes the statistical techniques as well as the methodology to
use them (Snijders & Bosker, 1999). It is an extension of multiple regression, in which eventual
interdependence between levels of analyses (e.g. “if the team lacks a physiotherapist, the team
approach is less family-centred” or “if parents attend team meetings, child specific treatment goals
are more often achieved”) can be defined. Within-group differences as well as between-group
differences are represented in a single analysis (hierarchical linear model), where group refers to the
variable at the higher levels of the nesting hierarchy (e.g. settings and teams). However, because of
the low number of children and professionals in the different disciplines (small amounts of data in
the subgroups of the nested structure) we, unfortunately, were unable to perform such multilevel
analyses. For future empirical research into the efficacy of team collaboration practices we do
recommend multilevel analysis so that all relevant elements of the complex process can be part of
the analysis and hence corrected for. For example, if a particular method of team collaboration
is the subject of study and participating families differ with respect to the characteristics of their
family system, the multilevel method can account for this variability in the analysis. The method
also affords an exploration of the role and effect of specific elements of the collaboration process
in relation to the effectiveness of the entire process. For such multilevel analyses to work, larger
respondent groups and fewer levels of analysis are recommended (e.g. evaluations of teams in one
or two settings or of teamwork among physiotherapists in five settings).

Finally, besides the targets proposed in the next section, future studies should carefully monitor
and evaluate the implementation of the instruments already in use, among which the Children’s
RAP, as well as the proposed instruments, viz. the MPOC, the family-specific MPOC-SP, the
GAS, COPM, and the ICF-CY. Empirical investigations of the complex process of teamwork
and the numerous elements that play a role should have mixed-method designs including both
quantitative and qualitative methods with the quantitative method(s) serving to investigate the
effects of the collaborative practices (Is there any effect? Does a particular effect occur?) and the
qualitative methods to gain an understanding of the process (Why do we see this effect?).

8.4 TARGETS, TOOLS AND RECOMMENDATIONS

With this descriptive study, a first important step towards improving the collaboration between
parents, rehabilitation and special education professionals in the care for children with cerebral
palsy in Dutch paediatric rehabilitation has been made. Based on the description and analyses of
current practices, we have identified three targets for optimisation:

I  To capture team collaboration in working protocols, defining team procedures and guaranteeing
the involvement of parents, rehabilitation and special education professionals.

II To raise the family-centredness of the care by focusing more on the unique strengths and needs
of individual families rather than on general client groups.

III To improve collaborative goal setting and promote adequate use of the Rehabilitation Activities
Profile for children (Children’s RAP) by defining minimal requisites that predefine where and
how the team members record and discuss the family’s needs, problems and goals.

Taken together, the results of our studies, our experiences during the data collection and the
theoretical knowledge from the literature as well as the available assessment tools allow us to
formulate specific recommendations for teams attempting to achieve abovementioned targets, which will be detailed in the next three sections.

I. Defining working protocols

Although collaboration of the three main stakeholder groups in child rehabilitation is endorsed and encouraged both nationally and internationally, protocols at the level of the rehabilitation centres and schools for special education that delineate their commitments to collaborate and that translate existing policies into practical, detailed guidelines are as yet lacking (Chapter 3). At the national level, broad guidelines on how to organise team collaboration are available, which the centres and schools can use as a starting point. Next, the key features and elements we identified (Chapter 2), especially the elements pertaining to the organisation of collaboration, the team process and parent involvement, should be incorporated into the protocol. The professionals can utilise the existing national guidelines and our list of salient collaborative elements as a checklist to see whether their protocols encompasses all the relevant features of team collaboration. Within the parameters of these fundamentals (the distance between centre and school, time available for team meetings, etc.), specific details may vary between settings, which is why we recommend each team to develop its own, custom-built protocol. Such protocols structuring collaboration in the clinical practice will make the processes transparent for all parties involved, as well as quantifiable and flexible. To encourage protocols to be drawn up and to realise sound protocols that will actually support the team members in their daily activities, requires the commitment and active involvement of both the parents and the various professionals. In view of the lack of carefully delineated, best practice guidelines on the organisation of teamwork, we feel that the following suggestions to improve collaborative practices that we based on the findings on the organisational characteristics of collaboration and team structures presented in this thesis, may be helpful.

As mentioned in the literature on the care for children with disabilities and in Chapter 3, paediatric teams are large and composed of multiple members from various disciplines and different organisations (Roelofsen et al., 2002; Nijhuis et al., 2007). In large teams (in our study teams had an average of 10.5 members) in which the various professionals all have their own viewpoints, preferences and agendas, collaboration in itself is already complex, let alone its organisation. Due to the large number of team members it is difficult to attune services and schedule meetings, and the necessity of reaching consensus and the need to give each member the opportunity to discuss his or her recent needs and goals all make the process extremely complicated. Seizing the opportunity to introduce or discuss particular needs, problems or goals tends to depend more on the personality of a team member than on the role he or she has in the actual service delivery or the priorities that have been set.

To empower parents in this process the “key worker model” has been developed (Appleton et al., 1997; Drennan et al., 2005; McConachie et al., 1999; Sloper & Turner, 1992). In this model of service delivery an intermediary is appointed who is to fulfil a guiding role within the child’s family and who acts as the single point of contact for the family, helping it to coordinate the care they require, not only within the health-care system, but also across systems (school, social services, financial resources, recreation, transportation, etc.; Drennan et al., 2005). A multitude of synonyms for key worker have been used, including case manager, link worker, guide, guide worker, service coordinator, family support worker, family liaison worker, and care coordinator. Besides the widely cited advantages of such a “care coordinator”, potential disadvantages should...
be taken into account. The system makes parents, for example, (too) dependent on one single person, i.e. the care coordinator, who, moreover, is often given insufficient weight. There may be problems with ultimate responsibility and it reduces contact between the parents and the professionals involved in their child’s care with communication running via the care coordinator, which can result in miscommunication. Moreover, the already large teams, their diversity and the often-changing complex needs and goals for child and family all place high, perhaps even too high, demands on the abilities and responsibilities of the care coordinator. The results of our investigations have unambiguously demonstrated that for team collaboration to be effective, comprehensive coordination of care and an explicit assignment of roles and responsibilities are requisite. The child’s parents and family should be maximally informed, involved and guided through the care process covering all organizations and professionals involved. However, in our view implementation of the concept of a care coordinator can only be a effective if roles and responsibilities and (organisational) conditions for optimal functioning of such care coordinators are most carefully delineated, and involvement of all parties is guaranteed and transparent.

Optimising care coordination may perhaps even necessitate a broader approach to the key worker concept, viz. the employment of a coordinator for the professional members of the team. Haig and LeBreck (2000) developed a tool that could be useful in this context. With their Issue-Oriented Rehabilitation Staffing (IORS) they advocate both autonomy and a sharing of tasks and decision making. At the same time the system provides structure, time limits and leadership. The coordinating role is flexibly assigned to team members depending on the issue that needs to be coordinated. The system could be exploited to structure the multifaceted collaboration requirements in paediatric rehabilitation. Although the original IORS mainly focuses on staff members, it can easily be extended to FCC settings as it allows for the flexible assignment of coordinators, implying that both professionals and parents can be awarded the status of coordinator depending on the issue at stake. The structure the staffing system offers can foster individual-based, dynamic care for children with special care needs and their families.

II. Making care genuinely family-centred

Everyone agrees that FCC should entail a balanced partnership between the parents and the service providers and that the families should have an important role in the decision-making process (de Geeter et al., 2002; King et al., 1997; King et al., 1997; King et al., 2004a; King et al., 2004b; Larsson, 2000; Law et al., 2003; Law et al., 2005; Simeonsson et al., 1995). Yet, although it is easy to appreciate the importance of treating parents as equal partners and regarding them as the experts on their child’s status and needs and hence involving them in decisions about the proposed care for their child, how to implement these notions in an existing and robust health-care system that primarily focuses on its professional staff that is used to making decisions without consulting the clients (child or families) is quite another matter. Once the philosophy of FCC has been adopted, various vital steps need to be taken involving all contributing parties and organisations to allow a proper application of the concept in the clinical practice, entailing continuous refinements of initial attempts to make the care genuinely family-centred. As translating new ideas into workable procedures always takes time and a great deal of practical experience, changing the existing system of service delivery also requires considerable effort of all concerned, as the literature on practical implementations of FCC so unequivocally illustrates. The available evaluations, however, mainly used group means to reflect the perceptions of parents and service providers on family-centred behaviours (Dyke et al., 2006), which method, does not tally with the core principle of FCC, viz.
the uniqueness of each child and family. Moreover, the studies mainly explored whether parents felt they were receiving FCC and whether the service providers thought they were delivering FCC, while the parents’ priorities, i.e. the different weights they might have awarded to specific behaviours, were not taken into account. Evidently, an accurate and reliable appraisal of FCC needs to comply with its basic principles and thus be family-specific and weigh the parental views on the care they received against the family’s specific wishes and needs.

With the studies presented in Chapter 4 and 5 we demonstrated that the Measure of Processes of Care (MPOC) and the family-specific use of the Measures of Processes of Care for Service Providers (MPOC-SP), combined with relevant supplementary ratings, afford such a precise assessment of FCC. When adequately applied, the measures also allow the identification of family-specific needs and wishes. The data reported in Chapter 4 clearly showed that still a considerable amount of parents did not always receive the care they desired. Frequently, the families, rehabilitation professionals and special education professionals from the same child-specific team tended to rate the nature of the care differently. In other words, they did not concur on what they deemed important in the delivery of FCC. By exploring such potential discrepancies in within-team views will allow FCC to be optimised, giving team members the opportunity to modify their services and devise and provide more individualized care programmes. The MPOC and the family-specific MPOC-SP can thus not only be used for single individual programme evaluations, but also for repeated quality checks and identification of areas for improvement.

Discrepancies in how care delivery is perceived are not the only barriers preventing a proper implementation of the principles of FCC. Service providers have mentioned institutional characteristics, e.g. organisational structures and boundaries, policies and institutional culture, as significant barriers to achieving true FCC (King et al., 2000). At present, most organisations in the Netherlands are service-led rather than needs-led. Making care truly family-centred entails that the organisational preferences and priorities first need to be tailored to accommodate the family’s needs and preferences before they can be incorporated into the organisation’s policies and procedures. The organization of care should not be tuned to groups of clients; instead, clients should be given the possibility to choose their own preferred “care pathways”. It is the families, with their unique strengths, resources and sets of needs, that should be at the basis of service delivery if we are to provide highly individualised and dynamic models of care (King et al., 2004b; Siebes et al., 2006). This is all the more important since the results of the study reported in Chapter 5 showed that parents differed considerably as to what they found important in their child’s care delivery, underscoring that there is no “uniform approach to parents” and thus underscoring the need for “optimally family-centred care pathways”. Parents should be free to determine their own role and level of involvement in their child’s rehabilitation process. Preferably, in optimal FCC programmes parents should always be invited to attend team meetings to allow them to elucidate and substantiate their needs. However, if they are unable or reluctant to attend, they should be offered an alternative to vent their views. Obviously, delivering genuine FCC programmes places high demands on the flexibility of all organisations, services and service providers, but it is highly plausible to assume that the more family-centred care becomes, the better the outcome will be for all parties concerned.

With the compilation and dissemination of hands-on information on the implementation and implications of FCC “Canchild”, the Canadian Centre for Childhood Disability Research in which researchers and clinicians have joined forces, has been instrumental in promoting FCC. Both families and service providers are furnished with an 18-part fact sheet series (Canchild, 2007;
www.canchild.ca) offering them guidelines and educational material on how to implement FCC and evaluate the care they deliver. Their straightforward objectives, organisation and layout make these sheets accessible for rehabilitation professionals, special education professionals, policy makers, service managers and families alike. The fact sheets underpin the broad scale of areas and aspects of service delivery in which family-centredness plays or should play a role. We think the Canchild initiative has great potential for service systems worldwide and should be made available for all families and professionals playing a role in paediatric rehabilitation teams in the Netherlands. We accordingly recommend the fact sheet series to be translated and adapted to the Dutch situation in collaboration with Canchild.

III. Improving collaborative goal setting and the use of the Rehabilitation Activities Profile for Children (Children’s RAP)

Although the use of the Children’s RAP, designed to promote a patient-oriented interdisciplinary team approach (Roelofsen, 2001), has certainly improved team communication and collaboration in Dutch paediatric rehabilitation, the current studies demonstrated that the requisites and qualifications of the profile’s framework are not yet optimally implemented. Moreover, the adaptations of the instrument that were needed to accommodate and fine-tune the treatment plans and education programmes placed even higher demands on the implementation process. Especially imprecise directions are complicating the proper application as the integrated, coordinated service plans (adapted from the Children’s RAP) often fail to adequately specify what, how and where the various team members should report. Clearly, if paediatric venues do not adhere to the basic requisites and recommendations of the proposed framework, this will frustrate the success of any interdisciplinary approach.

To enhance the appliance of the children’s RAP framework, a set of minimal requirements has to be developed that carefully delineates the requisites and observance of specific items of the profile and the persons that need to apply, monitor and document them. By detailing who reports what and where in the children’s RAP, the roles the parents and the various professionals are proposed to play will become clear to all parties involved. It is also strongly recommended to structure completion and distribution of the Children’s RAP for which the IORS staffing system proposed by Haig and LeBreck (2000) could be useful.

In our analyses of the Children’s RAP reports we focused on the way the needs, principal problems and shared principal goals of the children with CP and their proxies were formulated and we had to conclude that the documentation of these fundamental themes was not fully satisfactory. The rehabilitation profiles of the children did not provide information on whether parents and team members had set priorities or had reached conformity on the most important needs, problems and goals. We propose to modify the arrangement of the Children’s RAP and the structure of team meetings in such a way that team members are more convincingly induced to set priorities, strive for joint decisions and facilitated to improve their documentation of current needs, problems and goals.

As to the structure of the Children’s RAP, we found that only in 6% of the profiles needs for proxies (4% parents and 2% environmental system) were reported and that in only 9% of the reports, goals concerned the proxies (environmental system). As in the philosophy on FCC, care delivery should encompass all members of the family, the needs and goals of proxies are an essential element. To promote the assessment and reporting of their perspectives, we recommend
to separate the documentation of the needs and the goals of the child and its proxies. We also recommend to explicitly allow for an opportunity to indicate the absence of any needs at any point in the rehabilitation or educational process. A fixed response option, e.g. in the shape of a box to be ticked reading “no (new) needs indicated at the present time” should be provided. With the current version of the Children’s RAP it is uncertain whether no needs are present or whether they have not been reported.

Besides these modifications of the Children’s RAP structure, we strongly urge teams to explicitly invite parents to prioritize their and their child’s needs, either alone or together with (specified) professionals. Prioritisation of needs and problems is essential if teams are to decide on a shared principal goal. The COPM (Law et al., 1990) may be applied to assist parents in this process. Also, the Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968; Vlaskamp, 1993; Vlaskamp et al., 1993) may be used to facilitate the prioritisation of the principal problems and subsequently the decision on shared goals; the tool will help adjust the goals to the individual child, ensuring they are attainable for that particular child. These tools can be used both in the preparation of and during the regular team meetings in which goals are set and evaluated. In the Children’s RAP framework the team meetings are proposed to discuss priorities, make decisions and set goals, all in collaboration. At present, team members seem to not utilize the meetings optimally; reports indicate that they tend to inform each other rather than discuss priorities and allow for other opinions in their decisions. Future observational studies are proposed to determine whether this assumption is accurate and whether team meetings warrant improving or (re)structuring.

A final remark concerning the current use of the Children’s RAP, especially the recent adaptations as devised by various rehabilitation centres and affiliated schools: integration of goals and services is desirable but should not be forced to apply to all aspects of the child’s care and education. Only those aspects of the rehabilitation or educational process or home situation that may supplement or corroborate each other or that require fine-tuning between the professionals and parents should be discussed. Needs, problems and goals that are complementary and hence need not be attuned should be documented and reported but not discussed. It goes without saying that all (relevant) information should be clear and understandable and accessible for all team members, including the parents. However, although child-rearing practices at home, the rehabilitation programme and all educational activities are conditional upon each other, and parents and professionals should work closely together to jointly establish goals, all three stakeholder groups have their own ultimate goals and specific areas of interest. The foundation for integrated reports should always be the optimisation and coordination of care delivery and the prevention of overload for the child and its family. Informing each other about and discussing current needs, problems and goals should only serve to help set priorities, formulate shared principal goals, find common grounds or tweak competing views or interests.

In sum, services should be carefully attuned by joint priority setting and by reaching agreement on shared, interdisciplinary goals while still retaining time and space for own ultimate goals and specific areas of expertise and interest.
8.5 REFERENCES


CANCHILD (2007). 18- part fact sheets serie on family centred services.


